OPERATIONAL AUDIT OF THE DEPARTMENT OF HEALTH

COUNTY OF FRESNO

PREPARED BY
COUNTY ADMINISTRATIVE OFFICE
AUDITOR-CONTROLLER
APRIL 1979

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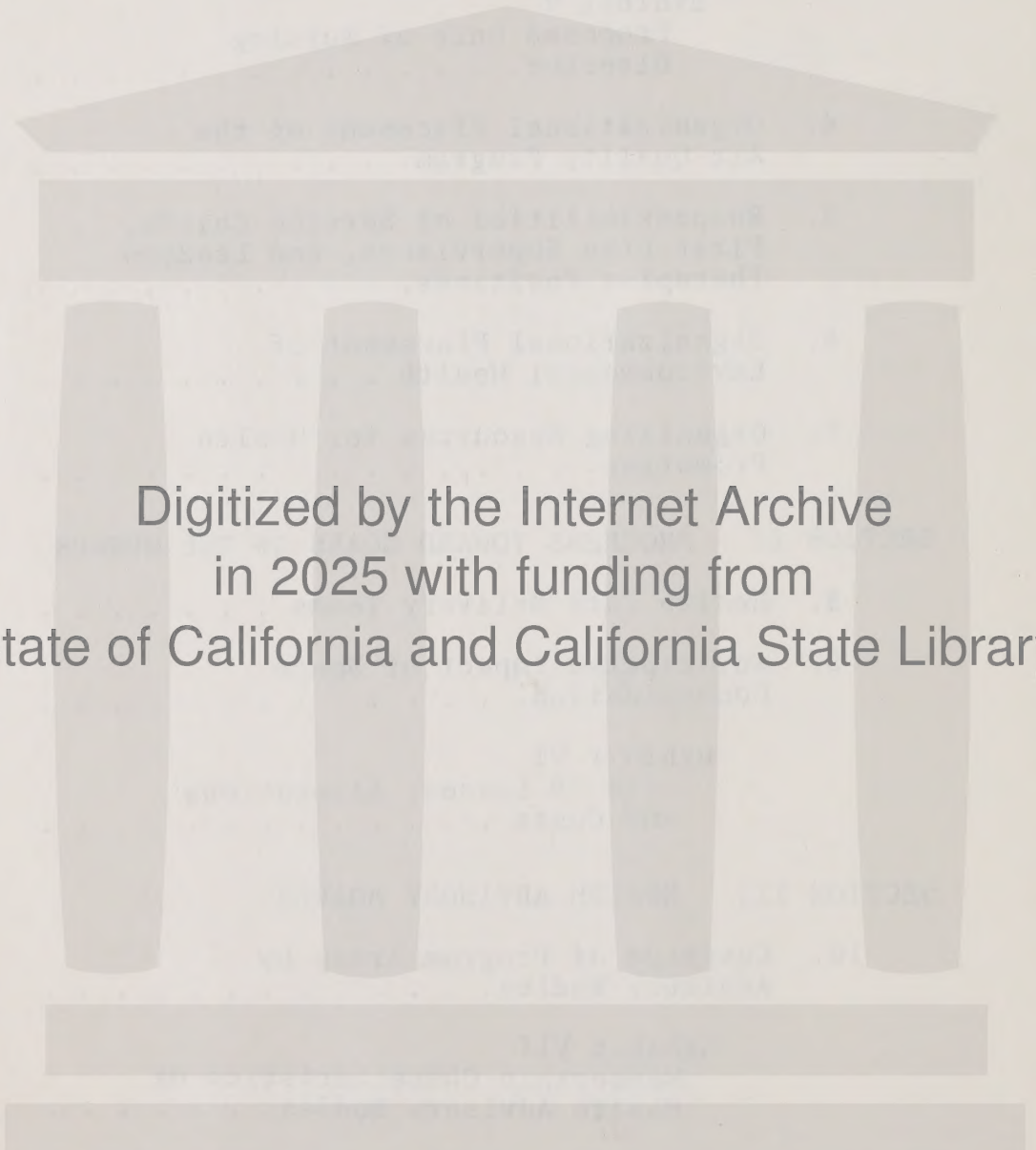

THE COUNTY OF FRESNO 1856

COUNTY ADMINISTRATIVE OFFICE

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COUNTY ADMINISTRATIVE OFFICER

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HUMAN SERVICES SYSTEM

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ENVIRONMENTAL MANAGEMENT SYSTEM

STANLEY D. GREENE
JUSTICE SERVICES SYSTEM

April 23, 1979

TO: Board of Supervisors

SUBJECT: Operational Audit of the Department of Health

On June 12, 1978, your Board approved the concept of recruiting a lay administrator to serve as the Director of Health, and to organizationally realign certain functions to improve the visibility and coordination of both mental health and public health functions within the Department of Health. At that time, your Board instructed this office to conduct an operational audit of the Department to evaluate the organization below the Director level, and the administrative practices and operations of the Department. As planned at that time, the audit has been concluded shortly after the arrival of the new Director to allow his participation and contribution in developing the following recommendations for organizational, operational and other adjustments to the Department of Health.

Work on the audit began immediately upon adoption of the CAO's June 12, 1978 report. We have interviewed personnel throughout the Department of Health, and staff of the Personnel Management Division. We also contacted a number of sources from other county health departments, State agencies, and community interest organizations for input to the study.

We also attended numerous citizen advisory board meetings to obtain firsthand knowledge about their interests and concerns. The Auditor-Controller assigned staff of his Internal Audit Division and Systems Division to examine the financial operations of the Department in conjunction with our study efforts, and we collaborated on many findings. His findings and recommendations as well as his comments on our findings, are included within the study

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report. We acknowledge the cooperation and assistance we received from these varied sources, without which this report would not be possible.

We have identified and prepared findings on 30 issues for which 118 recommendations have been made to improve organizational, operational, and administrative effectiveness. We also estimate a one-time savings of $144,263 and an ongoing annual savings of $210,000 as a result of our recommendations.

The Director of Health has reviewed the findings and recommendations in this report and generally concurs with the exception of direct administrative support to the Associate Directors of Health and Mental Health. His letter is enclosed and follows this letter. The report has also been reviewed by the various Health Department advisory bodies and their comments also follow this letter.

During our study, we were impressed with the variety and complexity of programs the Health Department operates. Since this breadth of activity tends to broaden our study scope, we had to concentrate our resources on problem areas rather than to attempt to also gauge the accomplishments of the Department. Our inquiry was directed to problems and concerns that have come to our attention, either during the preparation of the June 12, 1978 report to the Board of Supervisors on the top level organization of the Department, or subsequently during the operational audit. We therefore do not offer an overall assessment of the Department of Health.

With the exception of finding 21 by the Auditor-Controller, this study was conducted by the Management Services staff of the County Administrative Office. Assigned staff were Terence Henry, Principal Administrative Analyst and Project Director; Dwayne Smith, Senior Administrative Analyst; and Larry Tunison, Senior Administrative Analyst.

RECOMMENDATION

That your Board adopt the findings and recommendations contained in the report.

Warren D. Cantrell
Acting County Administrative Officer

L. D. Jernagan
Auditor-Controller

WDC:LDG:TLH:cf

County of Fresno
DEPARTMENT of HEALTH
MAILING ADDRESSES
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DIRECTOR
JAMES L. BLAKELEY

ASSOCIATE DIRECTOR
DAVE DUNCAN

April 19, 1979

MEMORANDUM

TO: Terence L. Henry, Principal Administrative Analyst

FROM: James L. Blakeley, Director of Health

SUBJECT: Comments on Management Audit of the Health Department

I have reviewed all findings and recommendations in the report on the Management Audit of the Health Department. I endorse the major thrust of the recommendations and feel that those which are specific to a new organizational structure will improve effectiveness and efficiency. With one exception, I concur with all the specific recommendations as well.

I cannot agree to the deletion of direct administrative support to the Associate Directors for Mental Health and Public Health. The incumbent Associate Directors are highly trained physicians and their compensation represents a considerable expense to the county. That expense is appropriate and is based on duties which require a medical education and/or high level administrative skills. I believe, however, that the effect of your recommendation to delete the direct administrative support now available to these two positions would necessarily involve the incumbents in administrative detail. This, in my opinion, runs counter to the major thrust of your report which argues for a more efficient use of costly resources. Furthermore, with respect to direct administrative support to the Associate Director for Mental Health, I have been led to understand by Mr. Robert Smith, Community Program Analyst for the State Department of Mental Health, that the Welfare and Institutions Code - Section 5751.2 requires that the Director of Mental Health have full-time administrative support. I am persuaded that the logic behind that regulation applies equally well to Public Health.

Therefore, I would argue that the Associate Directors for Public Health and Mental Health be provided administrative support at a level comparable to the Administrative Services Assistant I or II.

In addition to the above difference with the report, I have one additional concern which I feel compelled to state for the record. During my first two months as Director of the Health Department, I have seen considerable evidence of inadequate administrative support and control. However, I have also seen some very excellent administrative staff work. I concur with the report that some changes are indicated. I, too, believe that the staffing recommendations for the administrative area should result in a higher level of support and a greater analytical capacity. But, the fact remains that your recommendations call for a net reduction of 12 positions. This is in addition to the 70 positions already cut during the last year as a consequence of Proposition 13. I am apprehensive about further staff cuts at this time; and, would prefer first to have the opportunity to personally evaluate the underlying causes of the Department's weaknesses in the administrative area. There could be too few, rather than too many, resources in that area. The effects of your recommended staff reductions cannot be determined with finality until the Division of Personnel has evaluated the situation in detail. Meanwhile, employee morale deteriorates and that concerns me.

With the above reservations, I am willing to give your recommended staffing reductions a try.

JLB:sc
cc: Warren Cantrell
Ernie Morishita

CAO RESPONSE TO DIRECTOR OF HEALTH

The deletion of direct administrative support to the two Associate Directors that the Director of Health refers to are Chief Clerks. Our reasons for this recommendation are set forth on pages 10, 11 and 15. Under the proposed organization, there is no parallel organization structure for clerical resources since they are integrated into the programs to which they are assigned.

We do not support the addition of two Administrative Services Assistants to the Department of Health at this time. Direct salaries alone for these two positions, depending upon classification findings, would range from $29,495 to $34,164 at first step. The major thrust of our recommendations in findings 1 and 2 for administrative support are to streamline administration, develop categorical staff expertise as resources to all clinical program managers through the Associate Director of Health for Administration, and pinpoint responsibility. We are concerned that placement of administrative support directly with the clinical systems would obscure responsibility as it has under the previous organization. We would prefer to give the proposed organization an opportunity to support all the Associate Directors properly before these contingency resources be applied. We believe the proposed organization provides appropriate staff support to which Associate Directors may delegate administrative details.

We have conferred with County Counsel and the State Department of Mental Health and as of this writing do not believe Section 5751.2 of the Welfare and Institutions Code compels your Board to provide administrative support resources directly subordinate to the Associate Director of Mental Health. The County Counsel concurs with our office that the recommended centralized administrative and fiscal support system will meet the State's legal requirements. The same section of the State code definitely does not require such support directly subordinate to the Associate Director of Public Health.

The 70 positions eliminated from the 1978-79 budget had been vacant and frozen for up to two years and do not represent a recent curtailment of Health Department resources. The net reduction of 12 positions recommended in this report consists of four substance abuse positions and two nursing director positions, as well as six administrative support positions. We do not believe the problems of inadequate administrative support and control

we have identified are attributable to insufficient budgeted position strength. However, if that can be established in the process of correcting problem areas, such as in financial management, the appropriate mechanism to resolve it is through the budget request process for workload positions. Our office will give appropriate consideration to such requests as they are submitted in the future, and transmit our recommendations to the Board of Supervisors.

FRESNO COUNTY
MENTAL HEALTH ADVISORY BOARD

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SHIRLEY WILEY, M.A.

April 16, 1979

Supervisor Willard "Bill" Johnson
Fresno County Board of Supervisors
Hall of Records, Room 301
2281 Tulare
Fresno, California 93721

Dear Supervisor Johnson:

As you know, the County Administrative Office has conducted an operational audit of the Department of Health over the past eight months. During this time, the various Advisory Boards have been observed in operation and have had opportunity to review the final document which will soon be presented to the Board of Supervisors. Over the past month, the chairpersons and the Executive Committee of each of the Advisory Boards of the Fresno County Health Department have met to review the final draft of the audit and to comment on its contents. Several changes and recommendations were made and incorporated into the final document which will shortly be given to you.

The joint committees of the Advisory Boards commends the County Administrative Office for the operational audit which has been conducted and feels that this audit is a significant undertaking which will have critical influence upon the formation and direction of the Department of Health for years to come. Although this audit was conducted by the County Administrative Office and the report summarizes their observations over these many months, the audit also represents a coordinating effort by the Department of Health and the various Advisory Boards to produce this final document.

RECOMMENDATIONS: Advisory Boards are unanimous in recommending that the operational audit be accepted only as a guideline for Mr. James Blakeley, Director of Health, to use in providing direction and leadership to the Department over the coming years. We unanimously feel that Mr. Blakeley should have latitude and freedom to utilize the audit and implement as it is appropriate for effective and efficient operation of the Department of Health.

The joint committees also unanimously recommend the employment of two non-clinical administrative assistants: one to assist the Director of Public Health and the other to assist the Director of Mental Health. It is our opinion that this would maximize administrative efficiency and fully utilize the clinical skills for program development by the Directors of Public Health and Mental Health.

In addition, we recommend that there be a formation of the Health Advisory Council for Fresno County. It is our recommendation that this Council consist of the Chairpersons or their designee from the various Advisory Boards of the Department of Health to facilitate coordination and mutual effort for the benefit of the Department of Health and for strong advisory voice to the Board of Supervisors.

This audit is now accepted and as its recommendations are considered by Mr. James Blakeley and his staff, the Advisory Boards anticipate close ongoing cooperation and coordination over the coming year. We stand ready to comment and recommend ways in which the audit can be most effectively utilized for the building of a strong and well respected Department of Health.

Respectfully,

Allan G. Hedberg, Chairman
Mental Health Advisory Board

James H. Crocket, Chairman
Alcoholism Advisory Board

Ron Fick, Chairman
Coordinating Council for the
Developmentally Disabled

Stan Bohner, Vice-Chairman
Advisory Committee on Drug Abuse

Ruby Hefley, Chairman
Child Health and Disability
Prevention Program Advisory Board

AGH:jg

cc: Members, Board of Supervisors
James Blakeley, Director
Department of Health
David Marando, Health Advisory Boards
Department of Health

EXECUTIVE SUMMARY OF FINDINGS

Purpose and Organization of Report

The purpose of this review was to provide Health Department management, the County Administrative Officer, and the Board of Supervisors with an evaluation of the organization and a review of the administrative practices and operations of the Department of Health. This was an outgrowth of the County Administrative Office's June 12, 1978 report on the top level of the organization of the Department. That earlier study effort encountered several possible problem areas that precluded recommendations on the lower-level organization of the Department without additional field work and analysis. Consequently, the Board of Supervisors directed our office to conduct this operational audit.

We have attempted to describe situations as we have found them and develop constructive suggestions for improvement where we thought recommendations might help the Department conduct its operations more effectively and efficiently.

As a result of our operational audit review, 30 findings containing 118 recommendations have been prepared. For readability and continuity, findings have been grouped into seven sections based upon their similarity of subject matter:

1. Department Organization
2. Progress Toward Goals of the Merger
3. Health Advisory Boards
4. Management Planning, Direction, Control Practices
5. Financial Management
6. Program Management
7. Administrative Procedures

Each finding discusses a specific aspect of the operations of the Health Department that was originally identified during the preparation of the June 12, 1978 report, or came to our attention during the operational audit. A finding consists of a narrative description of the existing situation along with our analysis. The findings are then followed by specific action-oriented recommendations

indicating what immediate steps we believe management should take to improve or correct a particular situation or practice in the Department.

A summary of the findings follows in the remainder of this introduction. For a more thorough understanding of an issue or recommendations discussed in the Executive Summary, the reader should refer to the appropriate finding in the main body of the report.

Section I - Department Organization

Finding 1 - Organizing the Department of Health (p. 1)

This finding describes the current (Exhibit I) and proposed (Exhibit II) organizations of the Department of Health and the reasons for specific changes. It concludes that further extensive organizational changes, started by the Board of Supervisors on June 12, 1978, should be made. Our recommendations are intended to further improve program identity, visibility and advocacy; provide appropriate span of control; streamline the management structure and administrative support functions through consolidation; and promote staff specialization and competence of advice to the policy making level; bring balanced and appropriate management attention to all programs and objectives; improve coordination within and between clinical and administrative systems through clarification of responsibilities and pinpointing accountability.

An organization consisting of four major systems and a special program division reporting to the Director of Health is recommended. They are to consist of mental health, public health and environmental health programs, administrative support functions, and health promotion.

The principal changes in mental health are to transfer youth mental health programs into that system for better visibility and advocacy among all Short-Doyle programs. In public health medical programs, the changes are intended to consolidate the functions which, by statute, are to report to the Health Officer (with the exception of health promotion), and to recognize the differing urban-rural mixes of programs and manage them cohesively. In environmental health, we are proposing to elevate the level of management attention to this significant program area over that which could be expected under the interim organization, and reduce the number of management layers between the line programs and the Director of Health.

In administrative support, we have removed all clinically related functions and stressed the importance of specialization and expertise in the provision of financial, informational and personnel support services to the line systems. With the proposal to create a division for

health promotion for media and community organization and education efforts, we are supporting a special organizational exception to the four major systems. Its purpose is to assist in bringing increased Department attention to one of its professed major goals, and to provide an additional avenue for integrating public health and mental health efforts.

These changes would result in the creation of 36 positions and the deletion of 48 positions as listed in Exhibit III at an approximate net annual savings of $210,000, subject to classification findings of the Personnel Management Division.

Finding 2 - Administrative Support Systems (p. 30)

The administrative support functions of the Department of Health are situated within the Director's office and the Administrative Services, Financial Services and Program Planning and Development Systems (Exhibit I-F).

We found instances of fragmented authority and responsibility in financial management, information services, processing of grants and contracts. These functions are currently grouped in a manner that diminishes their possible coordination and control to ensure essential task accomplishment. We also found many functions within the three administrative support systems which were either not administrative or support. These include Consultation and Education, Nutrition, Director of Public Health Nursing, Public Health Laboratory and Crippled Children's Services. Placement of these services under the direction of administrative support managers does not give clinical program managers control over functions which are important to advocacy, supervision, and coordination for these units.

The realignment of functions as depicted in Exhibit II-F is proposed for delegating authority over resources commensurate with responsibility, improving accountability, and consolidating related functions to increase coordination and direction of staff groups.

Finding 3 - Director of Public Health Nursing (p. 37)

This position is presently placed within the Program Planning and Development System and is primarily assigned responsibility for developing mental health quality assurance activities, which does not fully utilize her expertise. It is recommended that the Director of Public Health Nursing report directly to the Health Officer. The Department should shift the responsibilities of the Director of Public Health Nursing toward public health activities as listed in Exhibit V, and provide clinical staff support and indirect nursing supervision in the Public Health System.

Finding 4 - Organizational Placement of the Air Quality Program (p. 46)

The air program is currently assigned to the Environmental Health System as one of several programs under the general supervision of an Assistant Director. Considering the size and sensitivity of the program, we encountered several reasons for considering placing the program higher within the County organization. The layers of management between the program's two supervisors and the Director of Health, already extensive, was increased by the interim organization. This affects the time and involvement managers up the line can devote to the program, and tends to fragment management attention to it. This probably obscures management's scrutiny of the program's priorities, effectiveness and planning efforts. We were also concerened that this situation promotes considerable non-explicit delegation of authority to the Supervising Sanitarians and Senior Environmental Engineer because they are the program's only full-time managers. This reduces the time they have for important functions of internal program supervision and support to field sanitarians.

The air program is relatively unique among environmental health programs because of its physical science orientation, and its engineering and instrumentation components. Its independence and isolation is also affected by its high level of grant subvention from the State and Federal governments, and the work goal conditions placed on that funding.

Despite the low level of day-to-day interaction between the air program and other environmental health programs, there are distinct advantages to their continued association. They are able to share clerical staff to cover absences and workload peaks, and common management that understands the effects of environmental factors on health. Within the Environmental Health System, the air program can be supported, represented, advocated, and guided by health management.

In evaluating the County's organization placement options for the air program, we identified three basic alternatives: reporting to the Department Head; separate department status; or continuing to report to Environmental Health with improvements in the current pattern.

Reporting directly to the Department Head would substantially alleviate layering short of increasing the number of County departments reporting to the Board of Supervisors. It deals also with the program's independence and isolation. However, it can eventually lead to a shift in program emphasis from health promotion to engineering and enforcement. Utilizing the Director of Health as a second level manager should be minimized wherever possible to avoid

interference with his executive management responsibilities for all Health Department programs.

Separate department status for the air program might facilitate intercounty coordination, but would also remove the program from health-oriented management. It would add to the number of departments the County Administrative Officer and Board of Supervisors must supervise, and probably increase administrative costs to sustain an independent department operation.

We are recommending that layering, independence, and health-oriented management concerns be addressed by modifications to the present organizational pattern. Management attention can be increased by lowering the level of the Air Pollution Control Officer to the Associate Director of Health and consolidating program management responsibilities in an Assistant Director of Environmental Health. Other recommendations on the organizational placement of the Environmental Health System reduce the number of management layers above the air quality program by one with its removal from the direct supervision of the Health Officer. Program independence issues not withstanding, we consider the benefits of environmental health management orientation to be more attractive at the present time.

Finding 5 - Responsibilities of Service Chiefs, First Line Supervisors, and Leadman Therapist Positions (p.54)

The Department's current practice is to designate program managers called "service chiefs" for mental health programs from various available classifications. These positions carry both administrative and clinical responsibilities, and distinctions between their authority and those of psychiatrists should be clarified. The designations are made at the discretion of the Associate Director of Health for Mental Health and not necessarily upon any formal job classification recruitment. Despite program organization, supervisory and management classifications still in use emphasize cross-discipline supervision rather than inter-discipline coordination. The salary range is associated with one of many clinical disciplines while the responsibilities vary with the size and complexity of the program. This may result in pay not being equitable with responsibility, or may cause inequity in pay with other service chiefs. We recommend that the Personnel Management Division, in cooperation with the Department of Health, review the job responsibilities of service chiefs. As a result of this review, a management job classification plan, such as a Service Chief I/II/III series should be developed for service chiefs as a replacement to the current use of discipline-oriented job classifications.

Finding 6 - Organizational Placement of Environmental Health (p. 59)

The interim organization, in establishing the Health Officer below the level of Director of Health, added an additional management layer between the Environmental Health System and the Director of Health (contrast Exhibits I-A and I-B, I-C) to meet statutory requirements. That development, in support of the establishment of a lay Director of Health, diminished organizational access to the top by a major program area component of the Department comprising about 15% of the total department staff. As a result, we re-evaluated this organizational placement during the operational audit.

Section 1155.5 of the Health and Safety Code provides that the County may remove Environmental Health from the direct supervision of the Health Officer, with the approval of the Director of the State Department of Health Services, provided the removal creates a comprehensive environmental agency consisting of at least all the County's environmental health functions. This "agency" could be made to report to the Director of Health, or placed outside the Department of Health reporting to the Board directly or through other administrative channels.

The alternative of separate department status was considered. This approach would be similar to that of Stanislaus, Santa Clara, Ventura, and San Bernardino counties. Since Environmental Health has a legitimate enforcement component and obligation, its removal from an educational/compliance oriented department might result in a shift to an enforcement/compliance emphasis.

The separation alternative would reduce management layers between line sanitarians and the department head from four to two with probably positive results. We found no evidence of an appreciable level of contact and coordination between Environmental Health programs and other Health Department services. We did, however, find a substantial level of contact and coordination with other County departments, the State and Federal governments, other local agencies, and other regional agencies. This alternative would also raise the level of visibility of Environmental Health. However, it has the disadvantage of creating another department head for the CAO and Board of Supervisors supervision, and introduces the possibility of increased administrative costs to duplicate support services now provided by the Health Department.

It is recommended the program should be directly under the Director of Health and headed up by a new position of Associate Director of Health for Environmental Health. This alternative reduces the number of management layers from

four to three; places the Director of Health in a better position to be knowledgeable about Environmental Health problems and development; places fewer administrative demands on the Health Officer; and balances the time spent by the Director between this program and his other four direct subordinates.

Finding 7 - Organizing Resources for Health Promotion (p.65)

In its 1976-77 Annual Report, the Department of Health published its goals and these are listed in finding 12. Health promotion and disease prevention services received prominent recognition in those goals and continue to be valued, though uncoordinated and minimally funded endeavors. This is probably because of the reliance of most of these services upon general county resources for financing, the fragmentation of inexplicit primary prevention responsibilities among many Health Department programs, the difficulties of quantifying cost-benefits though they can be significant, and the attention and priority commended by more directly curative programs that must respond to immediate needs of individuals already ill.

Further efforts are needed to make health promotion realize its promise. Additional financing should be pursued at the State and Federal levels. Also, the Department could better pinpoint the responsibility for health promotion and primary prevention planning, coordination, programming and advocacy. Coordination and effectiveness of disease prevention and health promotion activities could be enhanced if core staff groups already involved in delivering these services were brought together and elevated organizationally. For this reason, we propose the formation of a new Health Promotion Division reporting to the Director of Health. This division would consist of two new positions of a Division Chief and secretary, plus the existing staffs for the functions of Mental Health Consultation and Education, Public Health Education, Nutrition, and Community Relations.

Section II - Progress Toward Goals of the Merger

Finding 8 - Health Care Delivery Teams (p. 73)

When the Public and Mental Health Departments were merged in 1974, the purpose was to provide more coordinated, efficient and appropriate service to the client through integration and decentralization. The team approach to health care was to be utilized as the catalyst of clinical integration. Services were to be more available to clients through decentralization of services within the County.

While tremendous strides have and continue to be made toward multi-disciplinary team integration in the Decentralized Health System, the Department faces a more difficult challenge to extend its commitment to an integrated health delivery approach in its centralized public and mental health programs. With the coming relocation of most of its centralized services on the Mall, the Department has an improved opportunity to extend the concept to those programs as well. The mechanisms will nevertheless be difficult to develop given constraints of categorical funding, finite resources, the resistence of entrenched specialized programs, and established constituencies.

The Department should assess the practicality of health care teams for its centralized services; research the literature to locate where integrations have been tried elsewhere; and develop and test various team models to find the most cost-effective patterns.

Finding 9 - Anticipated Impact of Space Consolidation (p. 77)

The forthcoming move to the Fulton Mall Health Center will improve the Department's ability to deliver health services by consolidating the location of most department programs, staff support and management personnel which are currently scattered in a number of locations. The considerable involvement of department staff in planning of work areas should greatly aid in ensuring a smooth transition to the new facilities by staff and clients. It should greatly assist in the success of the layout for promoting efficiency and inter-program coordination.

Section III - Health Advisory Boards

Finding 10 - Coverage of Program Areas by Advisory Bodies (p. 82)

The Health Department works closely with seven citizen advisory bodies established to provide a vehicle for citizen advice, review, evaluation, and report on particular programs, services, and facilities they oversee. We found that while mental health, substance abuse, decentralized health centers and some public health programs have citizen advisory input, many public health and all environmental health programs do not have this type of input.

We have recommended that the Board of Supervisors consider the establishment of a public health citizen advisory committee for all public health programs not already covered by categorical groups, and an environmental health citizen advisory committee. If the Board decides to proceed, the County Administrative Officer and Director of Health should

prepare proposed duties and membership criteria for Board of Supervisors consideration.

Finding 11 - Department Assistance to Advisory Boards (p. 90)

The posture with which the Health Department's management and confidential employees assist, communicate, and interrelate with advisory boards can either be supportive of their independence and competence, or can compromise it. For advisory boards to be effective, the Board of Supervisors must have confidence that these bodies exercise independent judgment; act on sufficient information; and attend to matters pertinent to encouraging the appropriate delivery of effective health services in the programs they oversee.

We observed department management or confidential employees interrelate with advisory boards by: 1) providing secretarial support; 2) giving briefings of fact on program points of information; 3) at the request of advisory bodies, explain management proposals, policies, and procedures; 4) participate in discussions as though an ex-officio advisory board member; 5) lobbying for advisory board endorsement of some specific proposals of a program or higher level manager. We have reservations about the effects of the latter two activities on the appearance of credibility of advisory board advise, and therefore their effectiveness.

Management and confidential employees are too closely associated with official County policy or the process of formation of Department or County policy to be regarded as independent or unbiased advisors and participants. Futhermore, advisory boards partially derive their usefulness to the Board of Supervisors by the diversified sources of information they can bring to bear in forming their advice to the Board. Those sources therefore should be relatively free of management views, because the Board receives management's input directly.

Section IV - Management Planning, Direction, and Control Practices

Finding 12 - Program Planning (p. 92)

The Department has had extensive planning mechanisms in one form or another for many years. These have resulted largely from State and/or Federal requirements associated with grant or subvention funding of local public and mental health programs. Overall, the Department's planning mechanisms are quite commendable.

The Department places primary responsibility for plan development with the system responsible for providing the

service, including the writing of Management by Objectives/ Zero Base Budgeting (MBO/ZBB) statements. Administrative staff have assisted with technical finance, MBO, and evaluation technique advice, together with scheduling plan development tasks and making presentations to advisory boards and the Board of Supervisors. We are recommending that the Mental Health System take responsibility for scheduling the preparation of formal planning documents and presentation of plans to appropriate review agencies such as the Board of Supervisors and county health advisory boards. Administrative support staff would cintinue to provide technical financing, MBO, and evaluation support to these planning efforts.

We are also recommending the Department periodically review its basic goals, as it now does its specific MBO program goals.

Findings 13 and 14 - Program Review and Evaluation, and Their Utility to Top Management (p. 97)

The Department's program evaluation efforts have largely been directed toward trying to measure the effects of carefully defined variables on client-outcome or client-status. We are recommending that the Department place more emphasis on evaluation of administrative issues through cost-benefit analyses, operational analyses, and exploration of alternative approaches to providing services. This may help to better conform to certain State code requirements, and to provide the kind of information which is more likely to address the values, criteria, and concerns of managers and elected officials who are accountable for the use of public funds.

Evaluation reports should contain explicit recommendations to make management aware of possible follow-up action to achieve improvements. To assist in accomplishing this redirection of emphasis, we are recommending some evaluation resources (two positions) be shifted to the Budget and Fiscal Section to provide the Department with an analytical resource with administrative expertise. We have also recommended that top level management have greater involvement in selecting and prioritizing programs to be evaluated, and in specifying the purpose and objectives of each study.

Finding 15 - Quality Assurance (p. 108)

Quality assurance refers to organized efforts to ensure competent clinical practices in health service programs. Quality assurance takes many forms including Joint Commission on Accreditation of Hospitals surveys, Professional Standards Review Organizations, admission and length of stay reviews (UR), peer reviews, and medication audits.

Although quality assurance efforts in mental health services are largely mandated, we concur with the Department that similar efforts should proceed in public health programs. We have recommended an additional position of Quality Assurance Coordinator to develop, administer, and coordinate the Department's quality assurance program, from within the Information and Evaluation Services Division. This organizational location will promote continuing feedback to top management on the quality of clinical services by its proximity to other information services units.

Finding 16 - Management Practices (p. 111)

Prior to June 30, 1978, the Department at varying times utilized elements of both a pyramid and matrix structure. The matrix approach probably resulted in more considered decisions, staff development opportunities for middle managers to participate in the decision-making process they might not otherwise have, and encouragement of initiative and motivation through the team approach.

While the Department reaped many of the benefits of a matrix management approach, there are indications a number of pitfalls of the approach also occurred occasionally: autonomy or vague specification of responsibilities, overlapping or fragmented authority and responsibility, unnecessary clearance by managers unfamiliar with or uninvolved with a particular project, initial preoccupation with internal process, territorial struggles, and frequent upward referral of issues to resolve conflict.

We have recommended a more traditional pyramid approach to the organization to overcome these problems. We also recommend that middle management concentrate their energies on the day-to-day operations of the divisions they manage. This would concentrate the consideration of broad policy issues at the Associate Director level, with middle managers responsible for advising top management on the effects of policy and various other issues on their operations based upon the new emphasis on their categorical expertise. They would concentrate on the efficient and effective operation of their program.

Finding 17 - Usefulness of Committees (p. 116)

The Department has made considerable use of staff groups, committees, and task forces to provide a forum of discussion, provide training, facilitate communications, and to address specific problems. Standing committees included the Management Group of 80, Administrative Staff Group, and the Personal Health Staff. Numerous task-specific committees were also utilized. Overall, they illustrate a definite pattern of use of extensive regular meetings as a mangement

technique. We surveyed 72 supervisory and management positions for the month of March, 1978, and found they spent an average of 23% of available working hours in conferences and meetings, at an estimated annual cost of $375,000.

We have recommended that the Department encourage staff to use conferences and meetings judiciously and rely more on other channels of communications such as reports, memos, or newsletter items. These mechanisms are much less expensive, and can be more precise, accurate, thorough, organized, and provide a good source for future reference and guidance.

We have also recommended that more attention be devoted to preparation in advance of meetings so business can be conducted as swiftly as possible, yet completely.

Section V - Financial Management

Finding 18 - Financial Management of the Air Pollution Control District (p. 120)

The full costs and revenues of operating the County Air Pollution Control District are budgeted in a Special District Fund. This fund has accumulated a surplus of $144,263 since 1974-75. The Department of Health should include the APCD fund balance as a financing source when preparing the APCD budget request. Anticipated APCD revenues that are considered fully collectible at the close of each fiscal year should be accrued as a financing source and to more accurately represent the annualized financial condition of the District. A fund balance can be averted in the future by adjusting the APCD budget during final changes to reflect APCD Board decisions and changes in revenue estimates that vary from the proposed budget.

We also discovered that significant air program related costs of the Public Health Laboratory were not captured by the Department's Accounting System as chargeable to the APCD for reimbursement to the General Fund.

We noted significant discrepancies between the budgets submitted with the County's Environmental Protection Agency and Air Resources Board grant applications and the APCD budget. Grant agencies should be given official budget figures of the District Special Fund, as well as reports of actual expenditures and revenues to that budget unit. Financial reports on the APCD Special District Fund and General Fund air quality cost center need to be improved for accuracy and completeness.

We recommend that an Assistant Director of Environmental Health singularly be given responsibility for coordinating the financial management of the District.

Finding 19 - Revenue Recovery Effectiveness (p. 128)

The Billing and Collections Unit of the Financial Services System is responsible for billing and collecting many of the accounts receivable in the Health Department. This unit needs to have specific written procedures and cross-training for its personnel to ensure a smooth, dependable work flow. The current monthly report of billing and collection activities does not indicate current accounts receivable balances. As a result, the report is of minimal usefulness.

There are no follow-up practices on accounts receivable except for a notice sent when mental health bills become 60 days delinquent, continuing monthly thereafter for two years unless the bill is paid.

We have recommended that the Department prepare written procedures for the unit, develop a revised monthly report of billing activities, and utilize the Auditor-Controller Collections Unit at the earliest possible date. The Department currently is conducting a review of billing and collection procedures, with the assistance of the Auditor-Controller, which should result in the improvement of operations.

Finding 20 - Use of Overtime and Extra-Help (p. 135)

We reviewed the Department's use of overtime and extra-help and found that the Department has significantly reduced its use of overtime and extra-help since July 1, 1978. We also reviewed the reasons for use of overtime for each affected position in the Department in January, 1979 and found the Department was using a minimal amount of overtime and extra-help and only when it was necessary.

The computer reports for extra-help and overtime do not provide complete and timely information by program. The Department should investigate the cost and feasibility of developing more useful and complete overtime and extra-help reports including exploring the possibility of revising current computer and manually generated reports.

Finding 21 - Auditor-Controller Findings (p. 137)

Financial Information. We noted that personnel in the Health Department Fiscal Services Section generally lack a comprehensive understanding of the Financial Management

Information System (FMIS) and an overall working knowledge of Health Department operations. Their specific job knoweldge appears adequate. Due to fragmented responsibilities and lack of coordination, accounting records are inaccurate and/or incomplete. Improvement of the current system is of more immediate importance than the implementation of a cost accounting system as we had originally set out to explore.

The Health Department Accounting Section is not reconciling FMIS reports with original documents, nor are FMIS reports distributed on a timely basis. Labor distribution reports are not reconciled with FMIS or actual payroll. Trust fund and bank account reconciliations were not complete. Work papers for reimbursment claims are not properly indexed, cross-referenced or fully documented. We are recommending these situations be corrected.

The Billings and Collections Unit is not consistently interpreting accounting policies and procedures. The manual accounts receivable system does not provide information reports, nor are records correct. This prevents staff from performing follow-up collections on accounts. We are recommending a full-time accountant be responsible for managing this unit, and that manual accounts receivable systems be revised to enhance collections and reports.

Internal Control. In the Billings and Collections Unit, payments are not always immediately receipted or deposited promptly due to the cumbersome system and lack of information. Cash handling functions are not adequately separated. Responsibilities of employees are not clearly defined. Subsidiary accounts receivable are not reconciled to control accounts. Adjustments to accounts are not always documented or approved by supervisory personnel. These problems are a reflection of the lack of direct accounting supervision.

Section VI - Program Management

Finding 22 - Mental Health Patient Advocacy (p. 141)

Mental Health patient advocacy is the supportive representation of patients' interests and protection of their rights guaranteed by State and Federal laws. We examined alternative methods of providing patient advocacy including placing the advocate in another department, with an advisory board or contracting advocacy out to a non-government agency. We concluded that the Department should continue to provide patient advocacy and have recommended that a new position of patient advocate be created in the Department. Having the patient advocate position report directly to the Associate Director for Mental Health or the Director will

permit the greatest protection from potential interest conflicts at the highest level where unified supervision can be given.

Finding 23 - Classification Structure of Mental Health Program (p. 146)

In some instances, we found that positions were not being used to the extent of their professional qualifications. In other instances, we found that some semi-professional positions were being used in areas traditionally reserved for positions with professional qualifications.

We have recommended that the Personnel Management Division, and Health Department, complete a review of the classifications in the Mental Health System to bring position classifications into line with job duties.

Finding 24 - Psychiatric Residency Program (p. 149)

The Health Department sponsors a fully-accredited psychiatric residency training program. This is done in affiliation with the Department of Psychiatry, University of California at San Francisco School of Medicine. Since the program's inception in 1973, eight residents have graduated. While none of the graduates have practiced with the Department after graduation, several have expressed an interest in doing so. One graduate sought employment with the Department about two years ago, but there were no contract openings available at the time. The 1978-79 budget for the program was $503,096 of which 7%, or $35,200, is the County share.

The scheduling of residents utilized in the Department's mental health programs can be better coordinated to help meet assigned service workload. The Department should continue attempts to attract candidates into the Residency Program who are interested in community mental health programs.

Finding 25 - Residential Treatment Program for Youth (p. 152)

For ten years the Department has sought funding for a youth residential treatment program. Although there is wide support from local agencies for this type of program proposal, the State has never provided funding to operate the program. Since the Department has given this program a high priority, we believe top management should direct and coordinate the Department's efforts to pursue funding sources for this program. Complete project proposals should be submitted to potential funding agencies under the Director's signature. They should be accompanied by expressions of support from the Board of Supervisors and other area representatives at the State level, affected community groups and advisory bodies, and community leaders.

Finding 26 - Emergency Medical Services (p. 157)

Responsibilities for various aspects of the emergency medical services (EMS) system were distributed in 1975 among the County Administrative Office, Health Department, Comprehensive Health Planning Association(CHPA) (now the Health Systems Agency) and the Emergency Medical Care Committee (EMCC). Since that time, minimal progress has been made in the development of an EMS system. This is due mainly to fragmented responsibilities between the State and the County and within the County, changes in planning agencies, and EMS taking a lower priority than other projects in the planning agency, Health Department, and Administrative Office.

The Health Department has formed a multi-agency task force to assess the current status of EMS and propose a future course of action for the County and other agencies in administering the system. In the meantime, the Health Department should assist the EMC Committee in discharging its responsibilities, and with the Health Systems Agency in developing a plan for Emergency Medical Services.

Section VII - Administrative Practices

Finding 27 - Processing of Grant Applications (p. 161)
Finding 28 - Processing Contracts (p. 175)

We found that internally within the Department, sequential review by the three administrative support systems, unspecified review criteria, inadequately placed overall coordinative responsibility, and an unclear picture of the authority and responsibility of other County departments hindered the expeditious processing of grant applications and contracts.

We have recommended revision of the County Administrative Code to define contracts subject to the approval process, provide policy on use of the Request for Proposal, clarify responsibilities of all departments involved in the processing of grant applications and contracts, and a redesign of the Notice of Intent form for potential grants. We have also recommended the creation of a grants and contracts coordinator position in the Health Department to assume singular coordinative responsibility for expeditiously processing grant applications and contracts, monitor their administration, and ensure timely activation of the renewal process.

Finding 29 - Departmental Submission of Board of Supervisors Agenda Items (p. 181)

The Department should redirect its efforts in the organization, explanation, and presentation of information on Board

agenda correspondence so that duplication of effort will not be necessary.

We found no internal department guidelines for determining which documents leaving the Department are important or controversial and warrant review and signature by the Director of Health. We have recommended that all Board agenda correspondence be under signature of the Director or his designee to ensure that top management has reviewed and approved the item.

As with many County departments, most Health Department agenda correspondence to the Board of Supervisors is rewritten by County Administrative Office staff as part of the routine review process, and is then submitted to the Board as a County Administrative Office agenda item. This results in duplication of effort between the County Administrative Office and the Department, and develops departmental dependence on the CAO to prepare proper transmittal correspondence and to ensure quality. CAO analysts tend to catch gaps or errors in logic of department submissions, but important points of information taken for granted by the Department may be unanticipated by CAO staff and left out of the agenda item.

Finding 30 - Standard Operating Procedures (p. 183)

We reviewed the Department's published Standard Operating Procedures Manual and we commend the Department for putting its policies and procedures in writing and providing for their wide distribution. We found that aspects of format and content could be modified to facilitate use of the Standard Operating Procedures and that they should be written by assigned staff of the Information and Evaluation Services Division to promote consistency of quality. Management should check to see that each Standard Operating Procedure meets the objectives of management as it is released.

SECTION I. DEPARTMENT ORGANIZATION

1. ORGANIZING THE DEPARTMENT OF HEALTH

On June 12, 1978, the County Administrative Officer presented a report to the Board of Supervisors on alternative plans for a top level organization of the Department of Health. That report was intended to resolve fundamental policy issues that would materially affect the nature of the recruitment of a new Director of Health. The Board unanimously approved recommendations to gear the recruitment toward a lay administrator, realign functions to immediately improve the visibility and coordination of mental health and public health functions, and instruct the County Administrative Office to conduct an operational audit of the Department to evaluate the organization below the Director level, its administrative practices and operations.

The organization of the Department as depicted in Exhibit I-A was consequently modified under the acting Director of Health to the structure depicted in Exhibits I-B through I-F. This reorganization was considered the minimum necessary to meet the statutory requirements for a physician Health Officer and Local Director of Mental Health, yet permit the Board's priority directives to be implemented promptly. It was considered premature to reorganize further down into the organization at that time without more field work and analysis of the problems and needs of the lower level units of the Department, and without the participation of the new Director of Health. The further down in the organization changes are made, the more intricate the interrelationships that must be considered, and the more people that would be disrupted should any changes be made that require subsequent realignment if later found undesirable.

This finding, and the following detailed findings on particular major organizational issues, are the products of approximately eight months of field work and analysis, and subsequent consultation with the new Director of Health and various middle managers in the Department of Health. The Director of Health concurs with the organizational recommendations in these findings, with the exception of certain issues described in his letter preceding the Executive Summary.

Summary of Findings

The following findings conclude that further extensive organizational changes, started by the Board of Supervisors on June 12, 1978, should be made. Our recommendations are intended to further improve program identity, visibility and advocacy; provide appropriate span of control; streamline the management structure and administrative support functions through consolidation; and improve coordination within and between clinical and administrative systems through clarification of responsibilities and pinpointing accountability.

The following findings recommend an organization consisting of four major systems and a special program division reporting to the Director of Health. They are to consist of mental health, public health medical programs, public health environmental programs, administrative support functions, and health promotion. The principal changes in mental health are to bring youth mental health programs into that system for better visibility and advocacy among all Short-Doyle programs. In public health medical programs, the changes are intended to consolidate the functions which, by statute, are to report to the Health Officer (with the exception of health promotion), and to recognize the differing urban-rural mixes of programs and manage them cohesively. In environmental health, we are proposing to elevate the level of management attention to this significant program area over that which could be expected under the interim organization, and reduce the number of management layers between the line programs and the Director of Health.

In administrative support, we have removed all clinically related functions and stressed the importance of specialization and expertise in the provision of financial, informational and personnel support services to the line systems. With the proposal to create a division for health promotion for media and community organization and education efforts, we are supporting a special organizational exception to the four major systems. Its purpose is to assist in bringing increased Department attention to one of its professed major goals, and to provide an additional avenue for integrating public health and mental health efforts. See the following findings for a more detailed explanation of the rationale for these organizational designs.

Evaluation of Organizational Alternatives

There is no single way to correctly organize. This is especially true of a department with as many different programs as the Department of Health. However, the management literature does indicate some features to avoid and others which tend to be more successful. These features include such issues as span of control, authority

commensurate with responsibility, line and staff authority relationships, and departmentation for teamwork and efficiency according to size, product, client or territory. While keeping these limitations and techniques in mind, we have developed our specific recommendations to accomplish basic shifts in organizational emphasis and management in the Department of Health. It follows that the Board's evaluation of our proposals and any alternatives that may be considered must first be based upon whether there is agreement with our assumptions about what the reorganization should accomplish.

Our assumptions are explained in the detailed findings on various aspects of the organization which follow in this section, and which are also explained in Exhibit II-A. In summary, we would say that our objectives have been to streamline the administrative structure and processes, end instances of division of responsibility in order to improve accountability and performance, promote staff specialization and competence of advice to the policy making level, bring balanced and appropriate management attention to all programs and objectives, and meet statutory requirements.

For instance, in pursuit of these assumed goals, we have proposed a major organizational change of eliminating the level of Deputy Director of Health and its role in the policy and decision making process of the Department. We have instead proposed a more specialized middle management level of Division Chief, organizational separation of line and staff functions, and more functional groupings of programs and staff groups.

RECOMMENDATIONS

1. That the Board approve in principle the organization of the Department of Health as depicted in Exhibits II-A through II-F.

2. That the Board approve in principle the proposed creation of 36 positions and deletion of 48 positions in Exhibit III to implement the reorganization at an approximate annual savings of $210,000, subject to classification findings of the Personnel Management Division. It would be our intent to work with the Director of Health to eliminate old positions as proposed new positions are allocated and filled, to promote a smooth transition to the new organization.

EXHIBIT I-A

1977-78 DEPARTMENT OF HEALTH ORGANIZATION

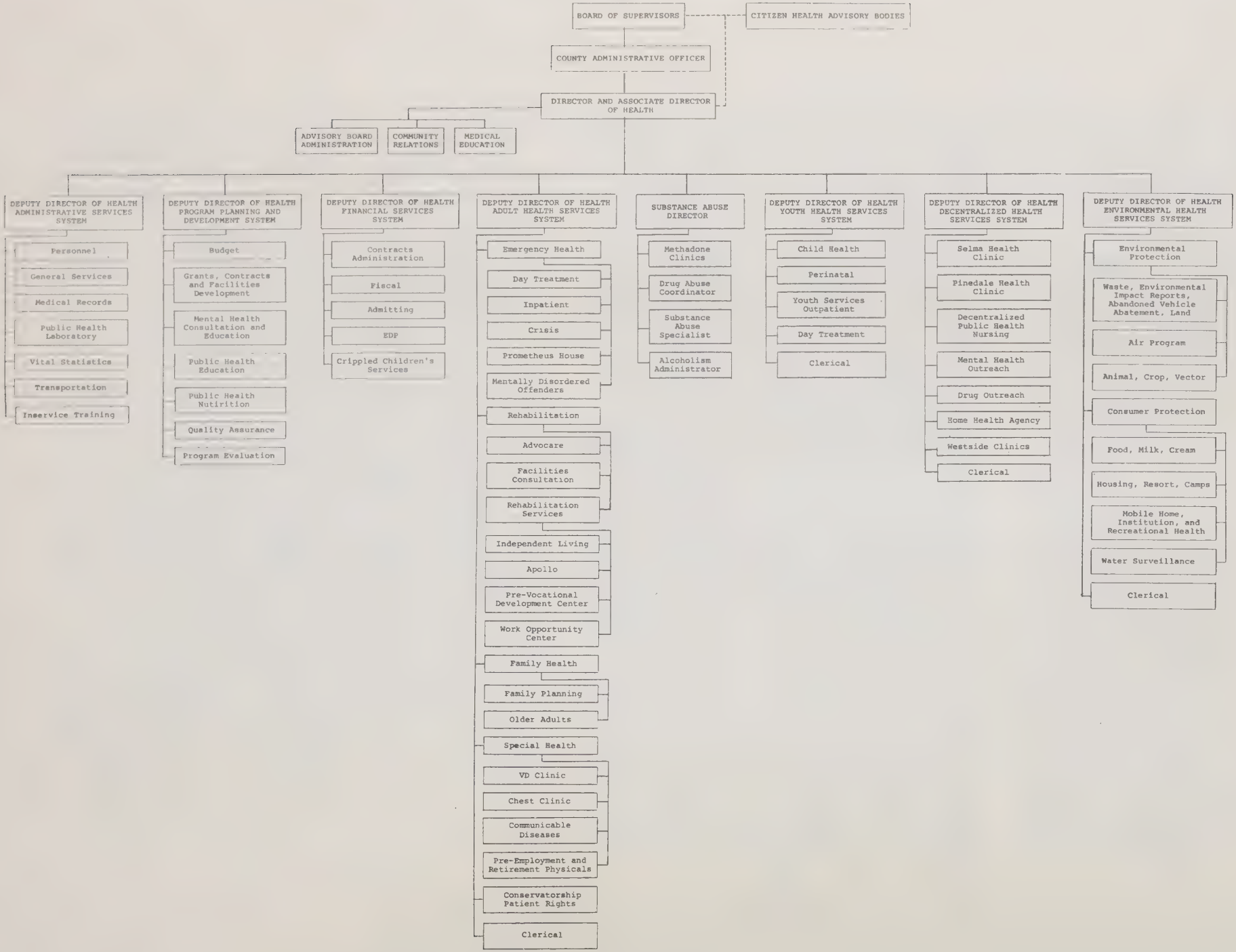


EXHIBIT I-B

CURRENT INTERIM ORGANIZATION OF DEPARTMENT OF HEALTH

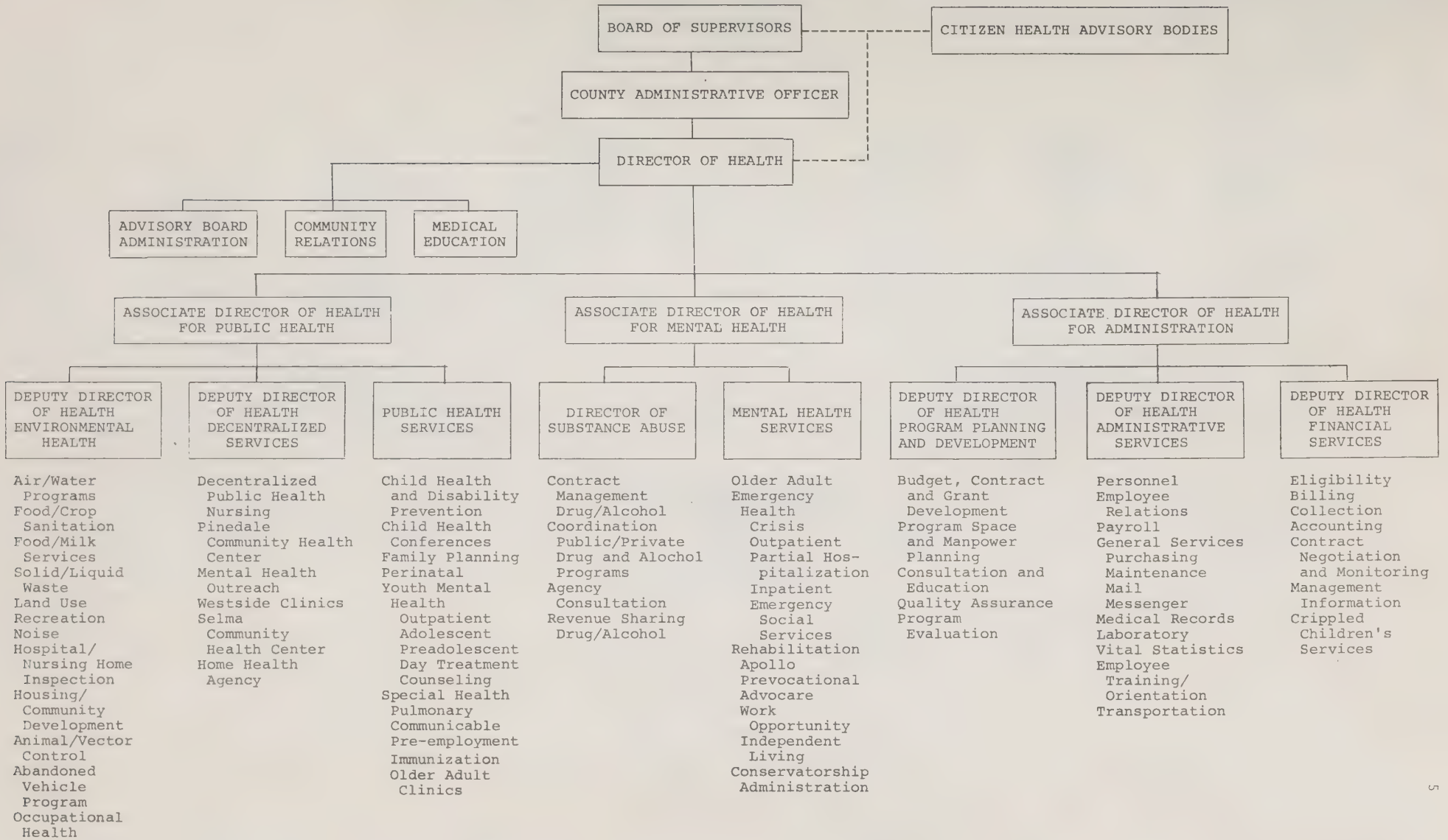
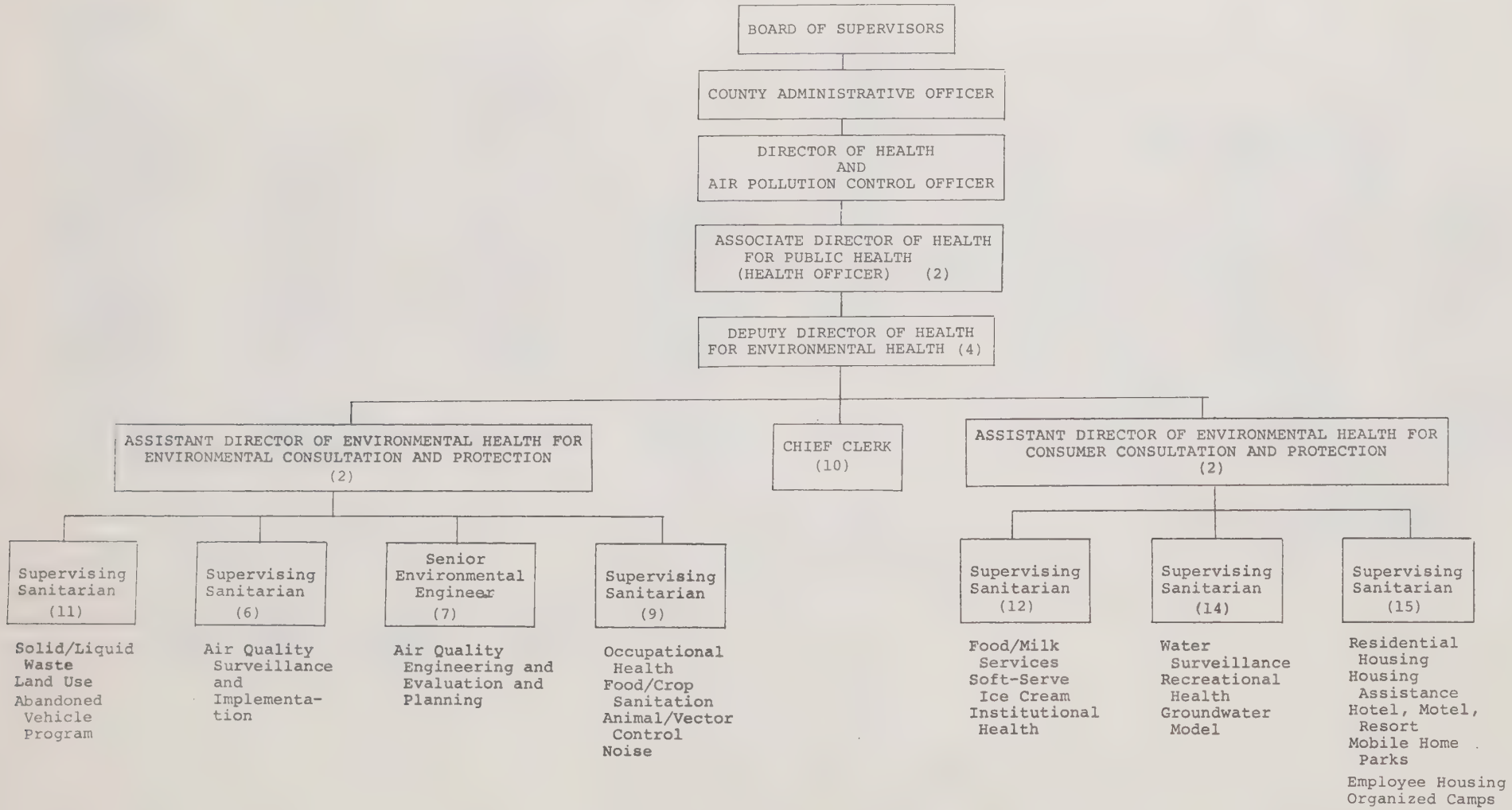


EXHIBIT I-C

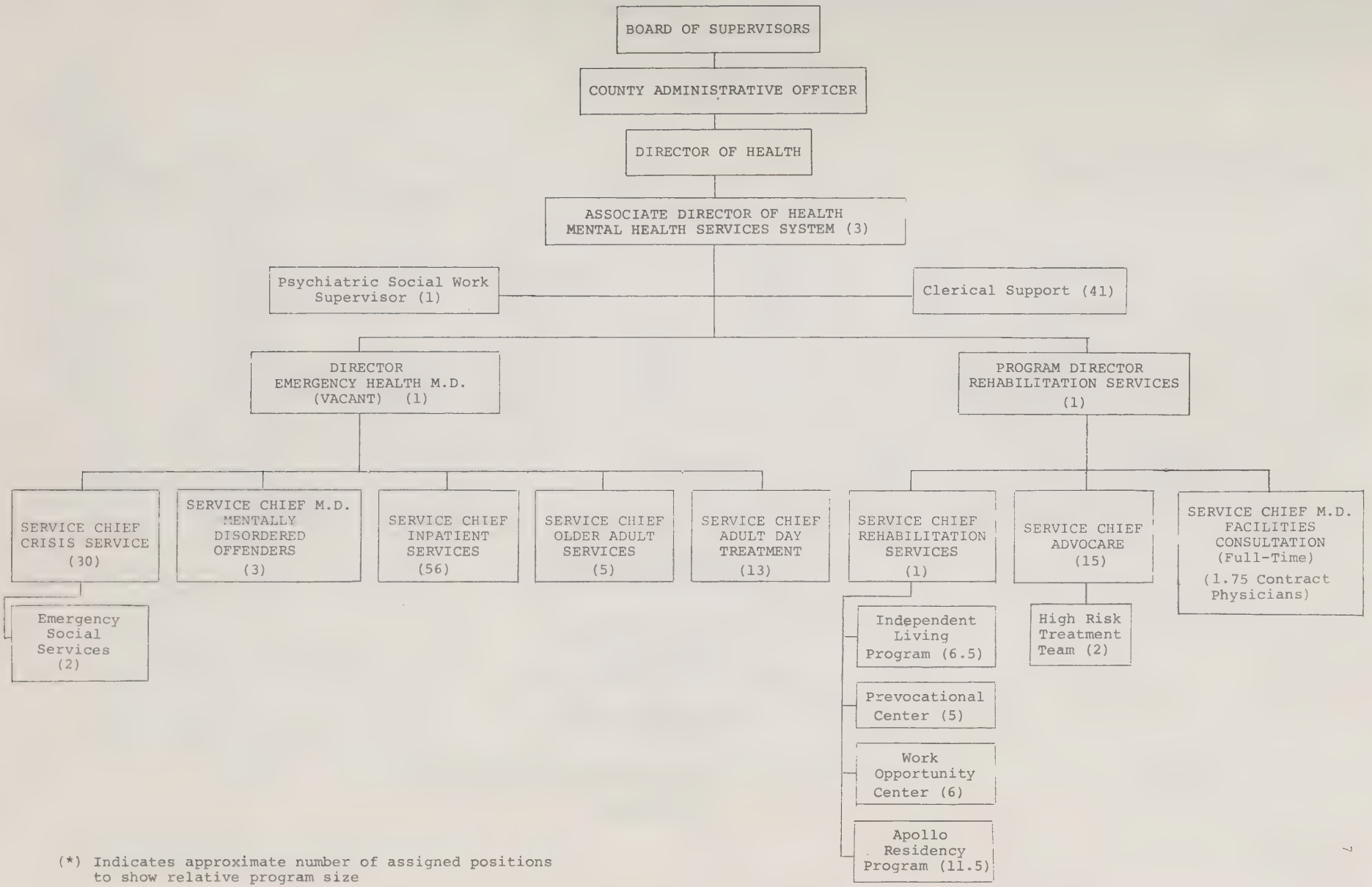
CURRENT INTERIM ORGANIZATION OF THE ENVIRONMENTAL HEALTH SYSTEM



(*) Indicates approximate number of assigned positions to show relative program size

EXHIBIT I-D

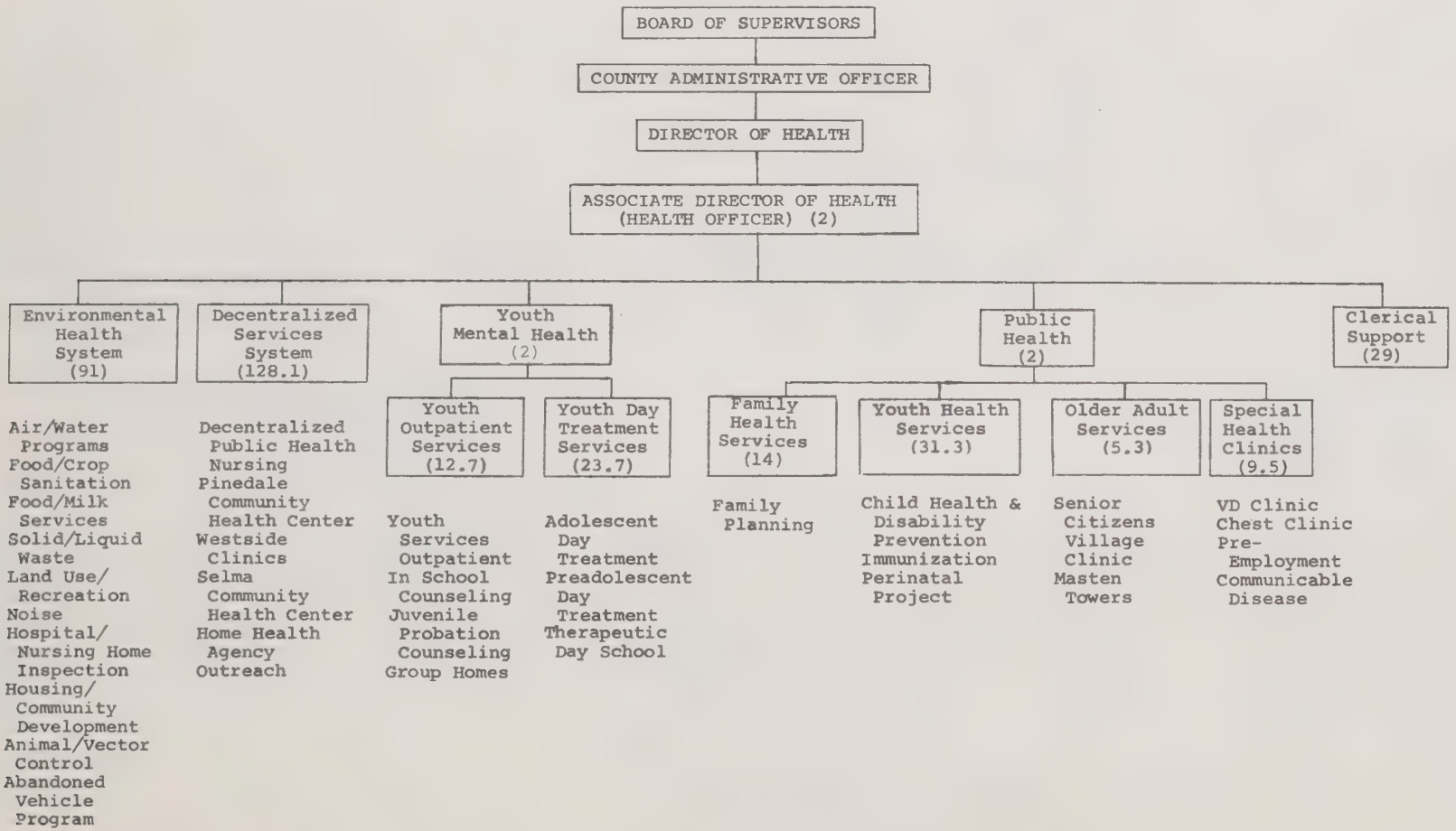
CURRENT INTERIM ORGANIZATION OF MENTAL HEALTH SYSTEM



(*) Indicates approximate number of assigned positions to show relative program size

EXHIBIT I-E

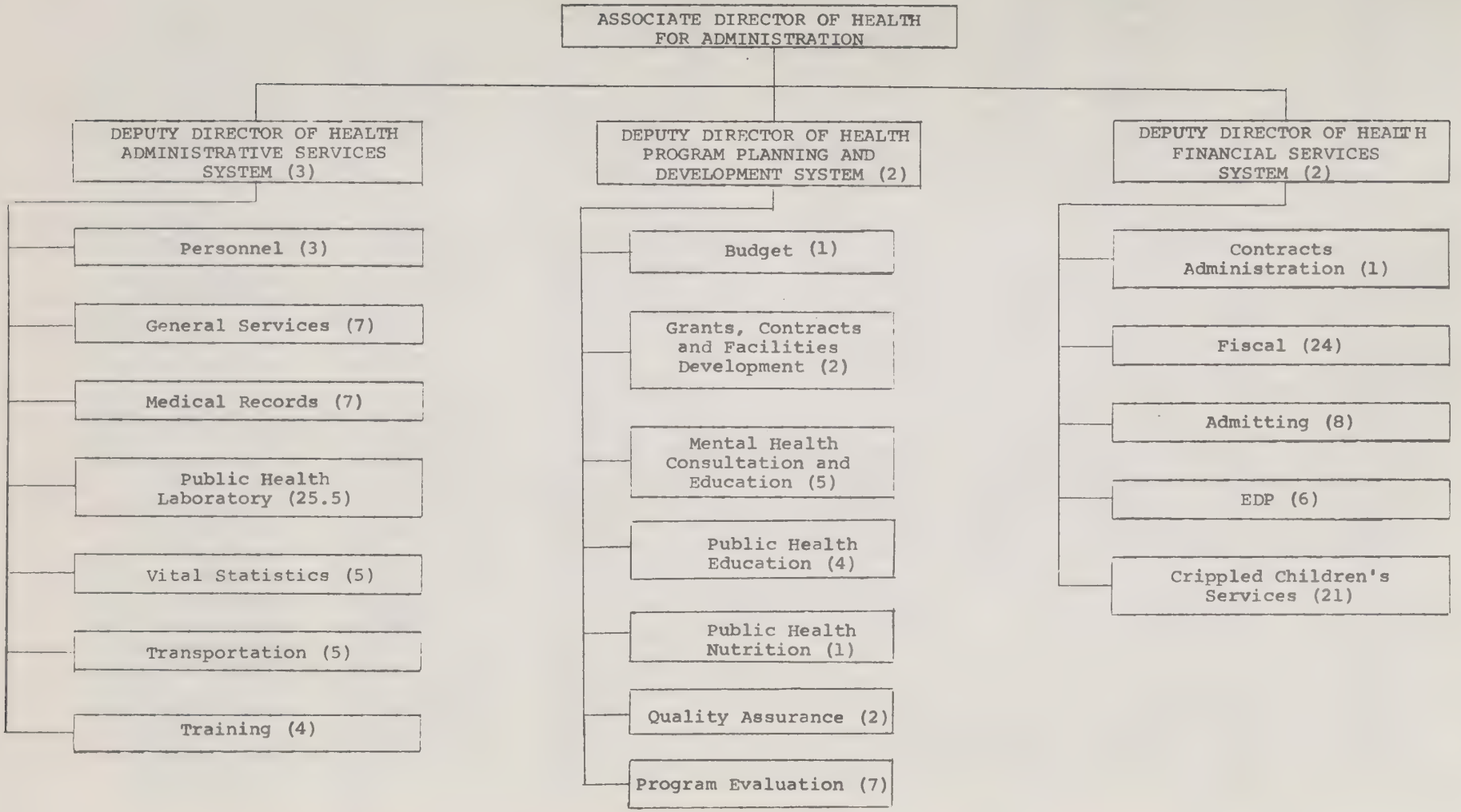
CURRENT INTERIM ORGANIZATION OF THE PUBLIC HEALTH SYSTEM



(*) Indicates approximate number of assigned positions to show relative program size

EXHIBIT I-F

CURRENT INTERIM ORGANIZATION OF THE ADMINISTRATIVE SYSTEM



(*) Indicates approximate number of assigned positions to show relative program size

EXHIBIT II-A

NARRATIVE DESCRIPTION OF RECOMMENDED ORGANIZATION AS DEPICTED IN EXHIBITS II-B THROUGH II-F

Organization of Environmental Health

The detailed finding on organizational placement of the Environmental Health System recommends that the system report to the Director of Health. The finding on organizational placement of the Air Pollution Control District calls for a shift of responsibilities to an Assistant Director of Environmental Health to include the functional title of "Assistant Air Pollution Control Officer." See these two findings for a description of conditions and an explanation of recommendations.

There is one other change to the Environmental Health organization we are proposing. Under the current organizational design, the clerical support to the system is supposed to be managed by a Chief Clerk in the office of the Deputy Director. What actually occurs is that the clerical staff take work direction from the professional staff to which they provide support. They should be coordinated by the supervisor or Assistant Director level manager responsible for the program(s) on which they work (just as are the professional staff). The presence of the Chief Clerk in the organization divides these responsibilities. Under the proposed organization, mutual assistance and coordination of clerical staff can continue to be arranged by the senior clerical person at each work site, but under delegation of authority from the resident Assistant Director rather than the Chief Clerk.

The duties occupying most of the time of the Chief Clerk in the Environmental Health System should be reassigned to other existing personnel. These include budget preparation, monitoring, and administration responsibilities which should be performed by management and supervisory personnel for better effectiveness and to pinpoint accountability.

Other administrative duties such as purchasing, personnel, and information gathering can also be delegated to other existing supervisory personnel more directly involved in each individual case. Consistency and quality control should be provided in the normal management review process of the system provided by the Director and Assistant Directors.

Organization of Mental Health

The organization shown in Exhibit II-D shows the proposed restructuring of the organization of the Mental Health Services System. This organization is intended to place all mental health programs (except decentralized Mental Health Outreach Services and Consultant and Education) under one system for improved communication and coordination of service. The proposed organization is also designed to bring mental health treatment programs within closer proximity to one another for improved visibility and advocacy. Program planning would be enhanced by utilization of available staff resources. Responsibilities between middle managers would be more evenly distributed and appropriately compensated.

Currently, a Psychiatric Social Work Supervisor reports to the Associate Director of Health and provides staff support for special studies, gathering information, reviewing legislation and acting as a patient advocate. However, this position has not been substantially involved in planning staff support, such as for the Short-Doyle Plan. This position does not supervise other employees. We have proposed in the finding on Mental Health Patient Advocacy that this position be retitled to reflect its primary responsibility and function, and that it also be used by the Associate Director to obtain program planning staff support.

The organization currently shows the clerical staff supervised by a Chief Clerk. However, clerical staff receive their work direction from the professional staff and ranking clerical supervisors in the programs in which they are assigned to provide support, and this appears appropriate. Service chiefs should be able to arrange additional clerical support from other programs if needed, or otherwise coordinate and prioritize the work of the clerical staff.

The current duties of the Chief Clerk can be reassigned to other personnel. These include budget preparation, monitoring and administration duties, personnel matters, and administrative information gathering which could be consolidated with, and more effectively performed by, other management and supervisory personnel as an aspect of their line responsibilities.

The Medical Education Program currently is assigned to the Director of Health. Under the proposed organization, the Director of Medical Education would report to the Associate Director for Mental Health. This would improve the opportunity for coordination between the schedules of resident physicians and the need of mental health programs for psychiatrist time, and minimize the second level management responsibilities of the Director of Health.

A contract physician post of Director of Emergency Health currently reports to the Associate Director and is responsible for budget controls, overall coordination of program activities, and the performance of service chiefs and employees in the programs under its supervision. This includes Crisis Services, the Mentally Disordered Offender Program, Inpatient Services, Older Adult Service, and Adult Day Treatment.

One position of Program Director for Rehabilitation Services has responsibilities similar to the Director of Emergency Health for the remaining adult mental health programs. These include the Independent Living Program, Prevocational Center, Work Opportunity Center, Apollo Residency Program, Advocare, and Facilities Consultation.

The current distribution of duties for these two positions does not equally distribute responsibilities between these middle management positions and does not facilitate coordination and communication among all the mental health programs.

The proposed organization would result in the Associate Director for the Mental Health Services System having three Service Chiefs III reporting to him instead of a contract physician Director of Emergency Health and a Program Director of Rehabilitation Services. This title would appropriately match this management level with the degree of responsibility and difficulty of the job as discussed in more detail in finding 5 on Responsibilities of Service Chiefs, First Line Supervisors, and Leadman Therapist positions. The finding explains that the eight service chiefs in the Mental Health System are the primary program managers and are filled by several employee classifications (Psychiatric Social Work Supervisor, Recreational Therapist, Supervising Mental Health Nurse) and also contract physicians. The development of a management classification series would help ensure their compensation and qualifications would more appropriately match their duties and program complexity.

Youth Mental Health Services is currently under the Associate Director of Public Health. Training, information exchange between staff, rassignment of staff to meet workload fluctuations, and the visibility of youth mental health in its competition for Short-Doyle funds with adult programs are not as effective as possible because of the current distribution of adult and youth programs between the Mental Health and Public Health Systems. The proposed organization places Youth Mental Health Services under a Service Chief III who reports to the Associate Director of Health for Mental Health. This Service Chief III would be responsible for overall supervision of youth mental health services and direct supervision of Youth Outpatient Services. A Service

Chief I would provide direct supervision of the Youth Day Treatment Program and report to the Service Chief III. The addition of the youth mental health programs to the Mental Health System should enhance the overall coordination and efficient delivery of all mental health services.

The Primary Mental Health Project, a youth mental health primary prevention program, is currently under the Consultation and Education unit. This program should be under the Youth Mental Health Services section to ensure effective coordination of its resources and program activities with other youth mental health programs.

The Inpatient Mental Health Services would continue to report to the Associate Director of Health for Mental Health and would be headed by a Service Chief III. This level is appropriate because of the number of subordinate staff and difficulty of the program.

The remaining adult mental health programs would be grouped under one Service Chief III with four Service Chiefs I or II reporting to this position. The Service Chief III would provide coordination and direction between the Crisis, Day Treatment, Rehabilitation and Advocare programs. This is an appropriate assignment based on the number of staff and complexity, size, and number of programs.

Smaller programs in terms of number of clients served and personnel assigned include the Mentally Disordered Offenders (MDO) Program, Facilities Consultation and Older Adult Services. Facilities Consultation would be reassigned to the Service Chief I position responsible for Advocare and the High Risk Treatment Team. The Older Adult Services would be assigned to the Service Chief I position responsible for the Adult Day Treatment Program and the MDO Program would be reassigned to the Service Chief II position responsible for Crisis Services. This organization would allow most psychiatrists assigned to these smaller programs to devote full-time to providing clinical services.

In the 1977-78 and current interim organizations, several psychiatrists below the level of Local Director of Mental Health have had an opportunity to gain administrative experience and become familiar with the Department's management structure. Under the proposed organization, no other psychiatrists have that opportunity. Since psychiatrists have a great deal of job mobility, it would be beneficial to the County to assign duties to up to one other psychiatrist that would give him high level administrative experience with the system. This would train one psychiatrist to assist the Local Director of Mental Health with his medical-legal responsibilities, fill in for him in his absence, or replace him upon termination. Giving a psychiatrist administrative duties in addition to his clinical assignments may require a higher level of

compensation; but that would also tend to promote continuity through better retention. The added job dimension would also offer the incumbent an added opportunity for professional development that would assist in recruitment and retention. For these reasons, we are recommending that no more than one of any of the Service Chief positions in the Mental Health System be a contract physician.

Organization of Public Health

Four specialized findings give detailed explanations of the major organizational recommendations affecting the Public Health System. Finding 3 on the Director of Public Health Nursing proposes a specialty staff support role for this position, reporting to the County Health Officer as provided in Title XVII of the California Administrative Code. Finding 7 on Organizing Resources for Health Promotion calls for consolidating existing units in Program Planning and Development and the Director's Office to redirect efforts toward stated department goals. It is suggested that two positions be added to effect that consolidation. Finding 6 on Organizational Placement of Environmental Health recommends upgrading the position of Deputy Director of Health to the Associate Director level reporting to the Director of Health rather than the Health Officer. Finding 4 on Organizational Placement of the Air Quality Program proposes a redistribution of responsibilities within Environmental Health.

For purposes of consolidation of supervision, economy, and elimination of duplication, we are recommending the deletion of the two positions of Assistant Director of Public Health Nursing which are assigned to the Home Health Agency and Family Health. These positions would serve no purpose in the recommended organization. The classification of the Supervising Public Health Nurse in the Home Health Agency is also recommended reviewed for appropriateness of classification.

We are also recommending that the services now included in the Decentralized Health Services System, with the exception of the Home Health Agency, continue to be consolidated in a division under the Health Officer. We are recommending the division be headed by an appropriately classified manager position. The Deputy Director of Health classification is recommended deleted to facilitate this re-examination of classification and to reflect the change in proposed scope of responsibilities of the position heading these services. The proposed division chief will have a manageable span of control, particularly considering the traveling that appropriately consumes much of his time in the course of managing these widely located clinics and outreach services. This configuration of programs will

also provide for the continuation of progress in the integration of public health and mental health services as described in more detail in finding 8 on Health Care Delivery Teams.

We are also recommending that the remaining public health functions, to be located jointly in the Fulton Mall Health Center, be headed by an on-site division chief. This position is offset by the deletion of the physician director of public health services, which is also to be absorbed into the proposed division.

The Chief Clerk positions in Public Health and Decentralized Health, as with the Environmental Health System, are recommended deleted since they are organizationally unnecessary. Their budget, personnel, and administrative responsibilities are more appropriately assigned to the first and second level line managers created in the proposed organization. Clerical support now organizationally shown reporting to these two positions actually take their work direction from on-site managers.

Organization of Substance Abuse

On July 1, 1978, the County-operated methadone maintenance program was discontinued and a contract provider took over. The only remaining Health Department operated substance abuse program at this time is the new drug abuse outreach program in the Decentralized Health Services System. That program consists of three outreach workers assigned to the north, west, and southeast sectors of the County. The Substance Abuse System has no responsibility for supervising the delivery of these outreach services.

The Substance Abuse System's remaining responsibilities are for alcoholism and drug abuse program planning, budgeting, advisory boards and interagency liaison, coordination of providers, program monitoring, and contract administration and control. These responsibilities still require program knowledge and expertise, but they are no longer involved in treatment program management. There has been a fundamental shift in Substance Abuse staff responsibilities toward contract management. With this change in responsibilities, we believe there has been a marked reduction in the level of staffing needed to conduct Substance Abuse System business.

Under the 1977-78 organization, the Substance Abuse System reported to the Director of Health. Since the June 12, 1978 report and reorganization, it has reported to the Associate Director for Mental Health. For purposes of reducing present overstaffing, and elevating these programs to their former visibility in the Department, the Alcoholism Administrator and Drug Abuse Coordinator could

report directly to an Associate Director, placing them at the second level below the Director as they were before the July 1, 1978 reorganization. The Associate Director would serve as the substance abuse director among his other responsibilities.

The selection of the most appropriate Associate Director position to which they should report is also important. There is a general reluctance among persons concerned with alcoholism treatment to have their program associated with mental health. They view alcoholism as a physical rather than a mental illness. Their concern seems to be that top management of the Mental Health System might impose a limiting psychiatric treatment modality on programs which are pragmatically developed to solve problems for which no single cause has been isolated, and no single modality is effective for every client. This issue doesn't appear to be based on concern about the views of present Mental Health System management.

There seems to be advantages to keeping the substance abuse planning and coordination functions closely linked so that they can be appropriately coordinated to deal with that portion of their clientele involved in both alcoholism and drug abuse. Drug abuse and alocholism providers can assist one another to maximize effectiveness and conserve finite resources. For these reasons we favor keeping the alcoholism and drug abuse programs in the same system for purposes of coordination and to strengthen contract management.

The system we propose for this placement is Public Health. This organizational location will provide clinically oriented direction and offer greater opportunity for interaction with the Health Department's other programs than in the past.

One of the two Substance Abuse Specialist positions is filled and reports to the Substance Abuse Director. It is used as a staff support position for administrative information gathering, budgeting, review of claims, and report preparation (primarily for drug abuse programs). These responsibilities should be delegated to the Drug Abuse Coordinator and Alcoholism Program Administrator to consolidate the points of program knowledge and expertise. It is our assessment that the Substance Abuse Specialist is not needed to meet these staff support responsibilities nor has the Alcoholism Program Administrator needed this support to date. For these reasons we are recommending the deletion of both Substance Abuse Specialists.

The deletion of these positions and a related secretarial position will result in a savings of approximately $70,000 per year to the drug and alcohol programs. These funds may be redirected to contract providers for treatment services, or used to replace County funds committed to these programs above the ten percent matching requirement.

We are also proposing the re-examination of the classification of Program Director for the Drug Abuse Coordinator since the methadone maintenance program is no longer County operated. Since the statutes require the County Drug Abuse Coordinator to be either the Department Head or Local Director of Mental Health, the actual staff position involved full-time in drug abuse programming may be designated as "assistant" for purposes of Civil Service classification.

Organization of Administrative Services

The Associate Director of Health for Administration will directly supervise three managers who now have consolidated and categorical responsibility for each of these administrative support services: personnel; budget and fiscal; and information and evaluation services (see Exhibit II-F).

All non-administrative support units have been taken out of the Administrative Support System and realigned with Public or Mental Health Systems. Consultation and Education, Public Health Education, Nutrition, the Public Health Laboratory, Community Relations, Crippled Children's Services, and the Director of Public Health Nursing were formerly located in administrative systems or the Director's Office. This has resulted in the transfer of 65 positions to the Public and Mental Health Systems. The transfer of non-administrative support units coupled with consolidated categorical responsibilities will permit the Associate Director of Health for Administration to directly supervise the administrative support functions under one system. This has resulted in the elimination of three Deputy Director positions in charge of the Administrative Services, Financial Services, and Program Planning and Development Systems.

The proposed organization establishes a Personnel Officer position to manage the personnel and inservice training functions for the Department (see Exhibit II-F). This position will assist the Director, program managers, and service chiefs in conducting personnel management practices appropriately and consistently in the Department. The position would have responsibility for developing department personnel policies and procedures consistent with County personnel provisions, developing, coordinating and negotiating physician contracts in conjunction with the County Administrative Office's Personnel Management Division, representing the Department at Civil Service Commission meetings, accelerating recruitment activities, advising on employee relations activities, and serving as liaison with the Personnel Management Division.

This position would also supervise the Training Officer--a new position offset by the deletion of one Psychiatric Social Work Supervisor position. The Training Officer will

manage the Department's inservice training activities, schedule seminars, classes, workshops and symposiums for improved health care delivery and administration, and work with line managers to develop appropriate training programs for the Department.

To consolidate budget and fiscal authorities and responsibilities, the plan establishes a Budget and Fiscal Services Division headed by a new Division Chief position. This division will assume complete administrative support responsibility for all budgetary and fiscal activities in the Department. Within this division, a Budget and Staff Services Section will provide the staff expertise and assist managers in preparation and administration of the Department's budget request. This section would consist of a Senior Health Services Program Analyst and two Health Services Program Analysts. Between budget seasons, this unit would perform operational improvement studies, legislative analysis and cost-benefit studies. These functions are recommended to round out the current evaluation activities taking place in the Department, provide a needed analytical resource to top management on administrative matters, and conform better to existing regulations and law governing program evaluations (see finding 14 - Utility of Evaluation).

Also established within this division is a Grants and Contracts Coordinator position. This position would provide the staff coordination and assistance for the processing of grants and contracts through the Department as we have recommended in findings 27 and 28 on processing grant applications and contracts. This position would be the liaison with other County departments, State and Federal agencies, and other organizations as necessary to ensure that grant applications are processed in a timely fashion. The remainder of the Budget and Fiscal Services Division would be comprised of the Accounting and Billing and Collections units of the existing Financial Services System and the Supply and Transportation Services of the existing Administrative Services System.

This proposed organization calls for the establishment of an Information and Evaluation Services Division which would be comprised of the Quality Assurance Program Coordinator, the Evaluation Services Section (formerly Program Information and Evaluation Section), and the Information Services Section.

The Quality Assurance Program Coordinator is established to ensure the Department meets legal requirements to have a quality assurance program operative by January 1, 1980. This is discussed in more detail in finding 15 on Quality Assurance. The Director of Public Health Nursing currently has this responsibility but we have recommended the transfer of that position to the Public Health System (see finding 3 on Director of Public Health Nursing).

Research and Evaluation Services (formerly Program Information and Evaluation Services) will continue to provide special program outcome studies, information, and program data monitoring. We have reduced this unit by two positions which is consistent with our findings on the evaluation process in the Department. We feel that the scope should be broadened from the strictly scientific approach and shifted to include studies of issues and methodologies of more immediate relevance or importance to top management. These savings are redirected into the Budget and Staff Services Section. This proposal leaves the Department with a sufficient client outcome evaluation resource for priority studies.

The Information Services Section would be headed by a new position of Information Systems Manager which is offset by the deletion of a Public Health Analyst position presently in the Statistical Services Section. The Public Health Analyst's duties may be reassigned to the Research and Evaluation Services Section where the Department's statistical analysis resources are situated. The Information Services Section would be comprised of the admitting functions, Medical Records, Electronic Data Processing Services and Vital Records. This would consolidate a great deal of the information processing activities currently existing in the Administrative and Financial Services Systems. This would also allow for singular management authority and responsibility for the provision of information services in the Department.

The Electronic Data Processing Services Section is comprised of two Data Processing Coordinators and four data entry and review personnel. The unit is responsible to provide the data entry and data review services for the fourteen systems and seven data entry projects in use by the Department. The Department's data entry needs have been under study by the Computer Services Department.

We believe that the Department can provide adequate data processing coordination using one position instead of two. The number of systems and projects and the number of subordinate personnel do not appear to justify two data Processing Coordinators. We feel the extra resources have been utilized by the Department to provide systems analysis and programming services that should be provided by the Computer Services Department.

Organization of Health Promotion

As one of its professed goals, the Department of Health seeks to promote the general level of physical and mental health of County residents. Activities to support these goals have included the Child Health Play and a media campaign in 1977 on the seven prerequisites to good health.

Staff groups with ongoing health education and prevention responsibilities include Public Health Education and Nutrition and Mental Health Consultation and Education.

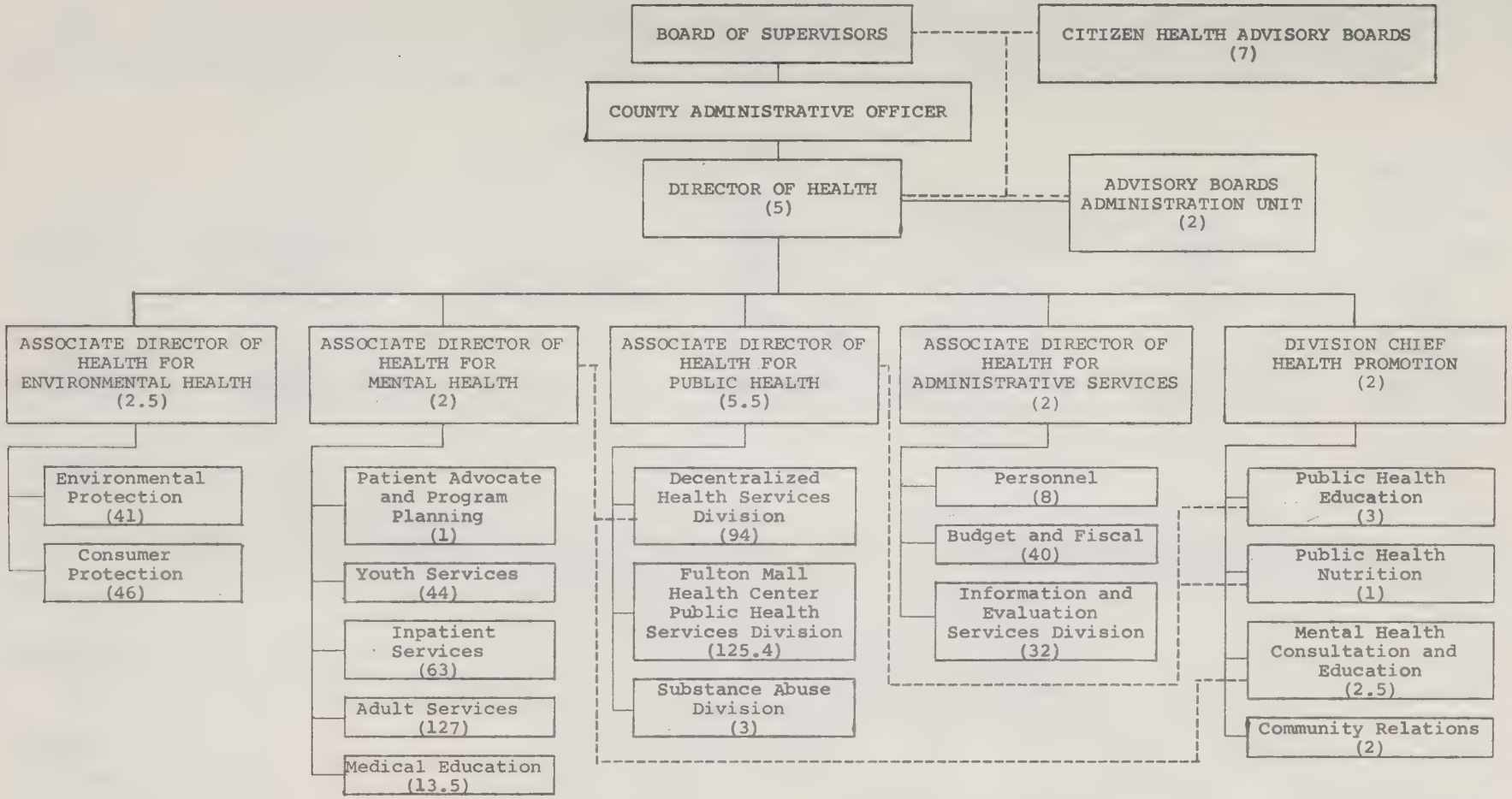
As explained in detail in finding 7 on Organizing of Resources for Health Promotion, we are proposing to form a special division outside the system structure to mobilize the Department's efforts toward these goals. Reporting to the Director of Health, a new Division Chief of Health Promotion would oversee the Department's central staff units that form the nucleus of its health promotion support functions. This configuration is expected to enhance efforts to plan, organize, coordinate, and advocate for health promotion and primary prevention.

AUDITOR-CONTROLLER COMMENT

Generally, we believe the CAO recommended organization will accomplish the objective to "streamline the administrative structure and processes. . .". Additionally, we believe all Department of Health activities, whether administrative or programmatic, should be examined for possible duplication of other County department functions. Be resolving any duplications, economies in operation and improved efficiencies may result.

EXHIBIT II-B

PROPOSED ORGANIZATION OF THE DEPARTMENT OF HEALTH



See Exhibit II-C for Functions and Subordinate Levels

See Exhibit II-D for Functions and Subordinate Levels

See Exhibit II-E for Functions and Subordinate Levels

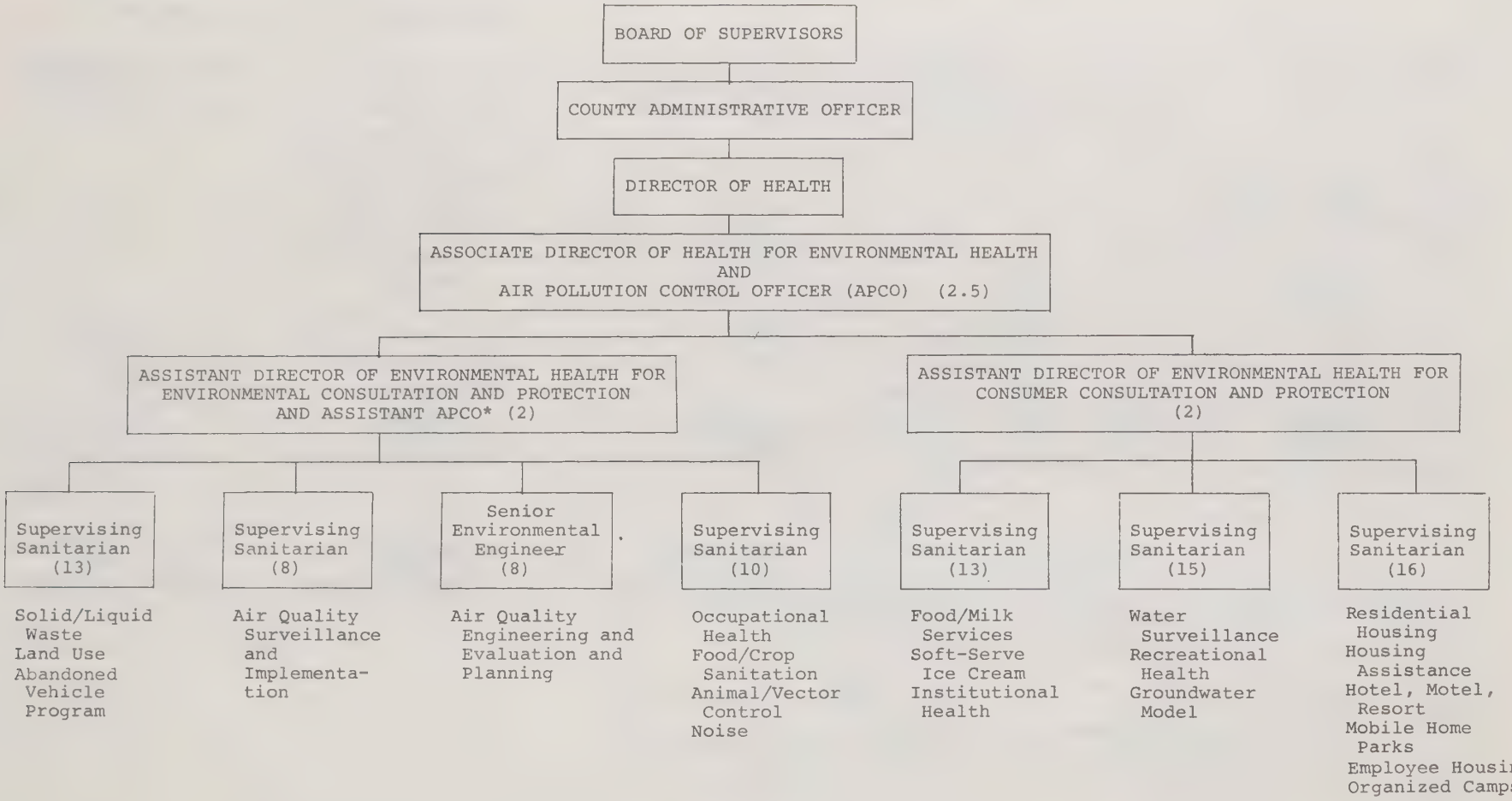
See Exhibit II-F for Functions and Subordinate Levels

----- Consultation and Program Coordination

(*) Indicates approximate distribution of positions to show relative program size. Subject to change.

EXHIBIT II-C

PROPOSED ORGANIZATION OF ENVIRONMENTAL HEALTH SYSTEM

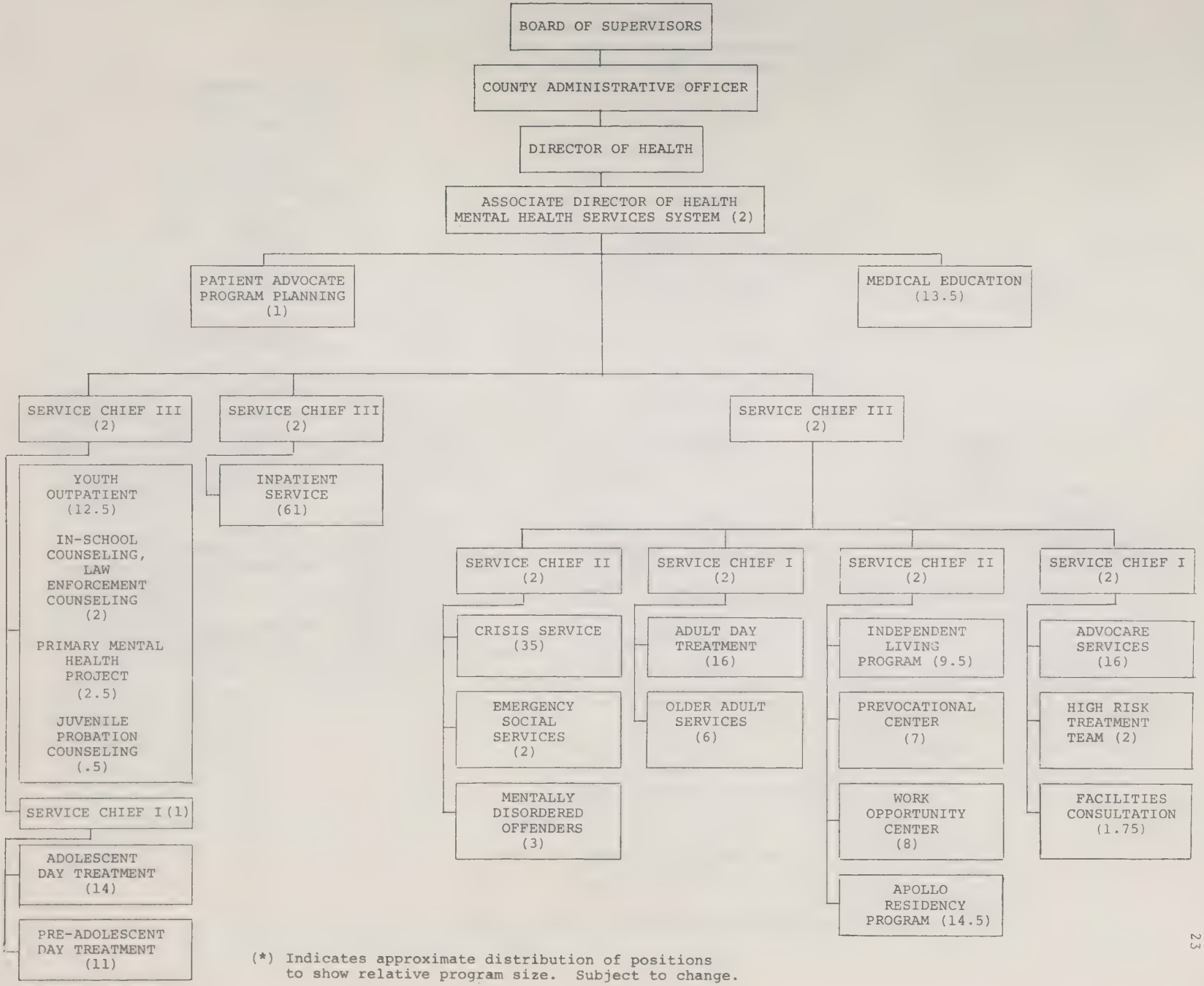


*As recommended in the finding on Organizational placement of the Air Pollution Control District, the Assistant Director of Environmental Health who is to serve as Assistant APCO may have to increase the proportion of his time spent on the Air Program. This may require the shift of some programs to the other Assistant Director, or for a Supervising Sanitarian to report directly to the Associate Director, to maintain sufficient management control of other environmental health programs.

(*) Indicates approximate distribution of positions to show relative program size. Subject to change.

EXHIBIT II-D

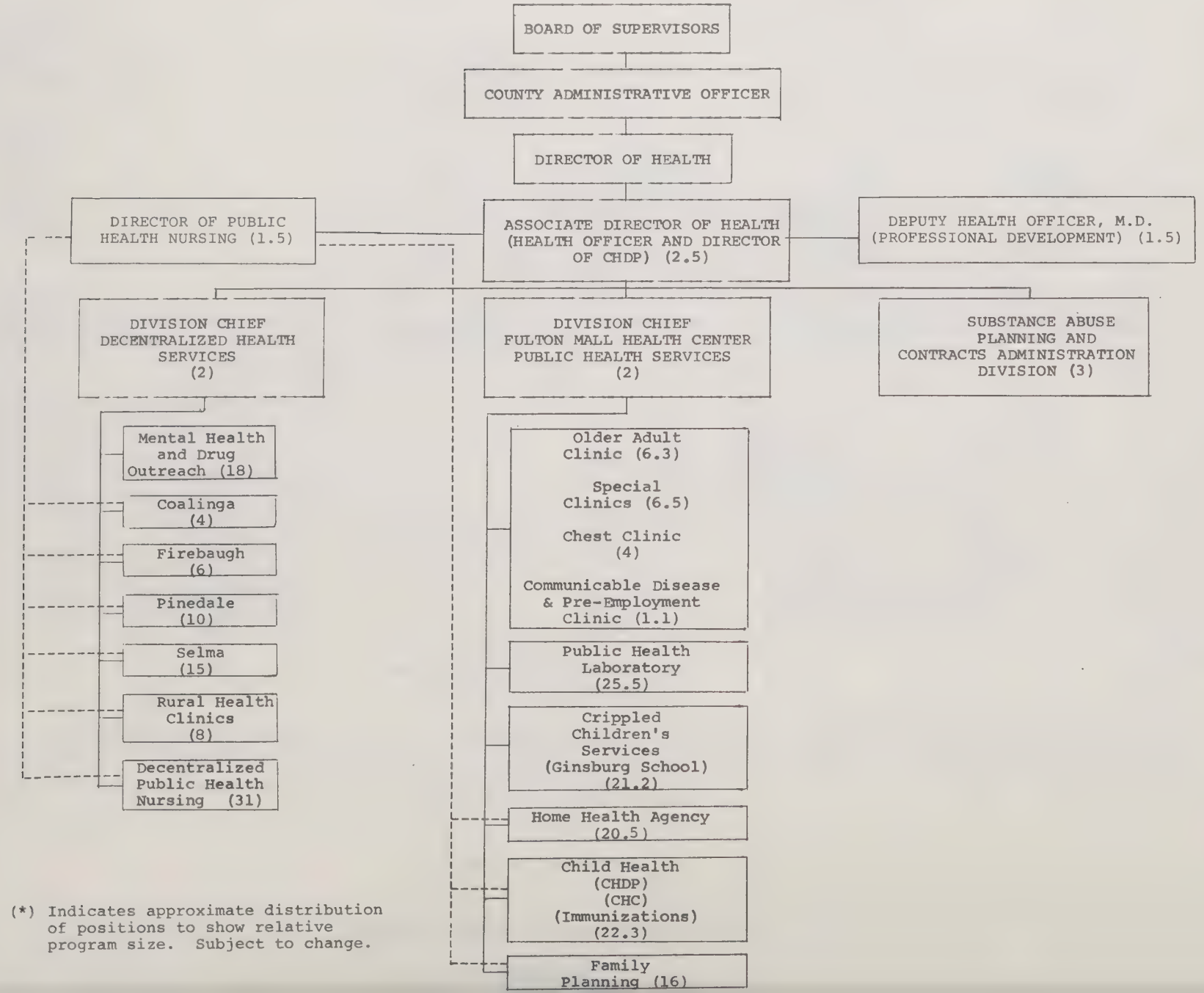
PROPOSED ORGANIZATION OF MENTAL HEALTH SYSTEM



(*) Indicates approximate distribution of positions to show relative program size. Subject to change.

EXHIBIT II-E

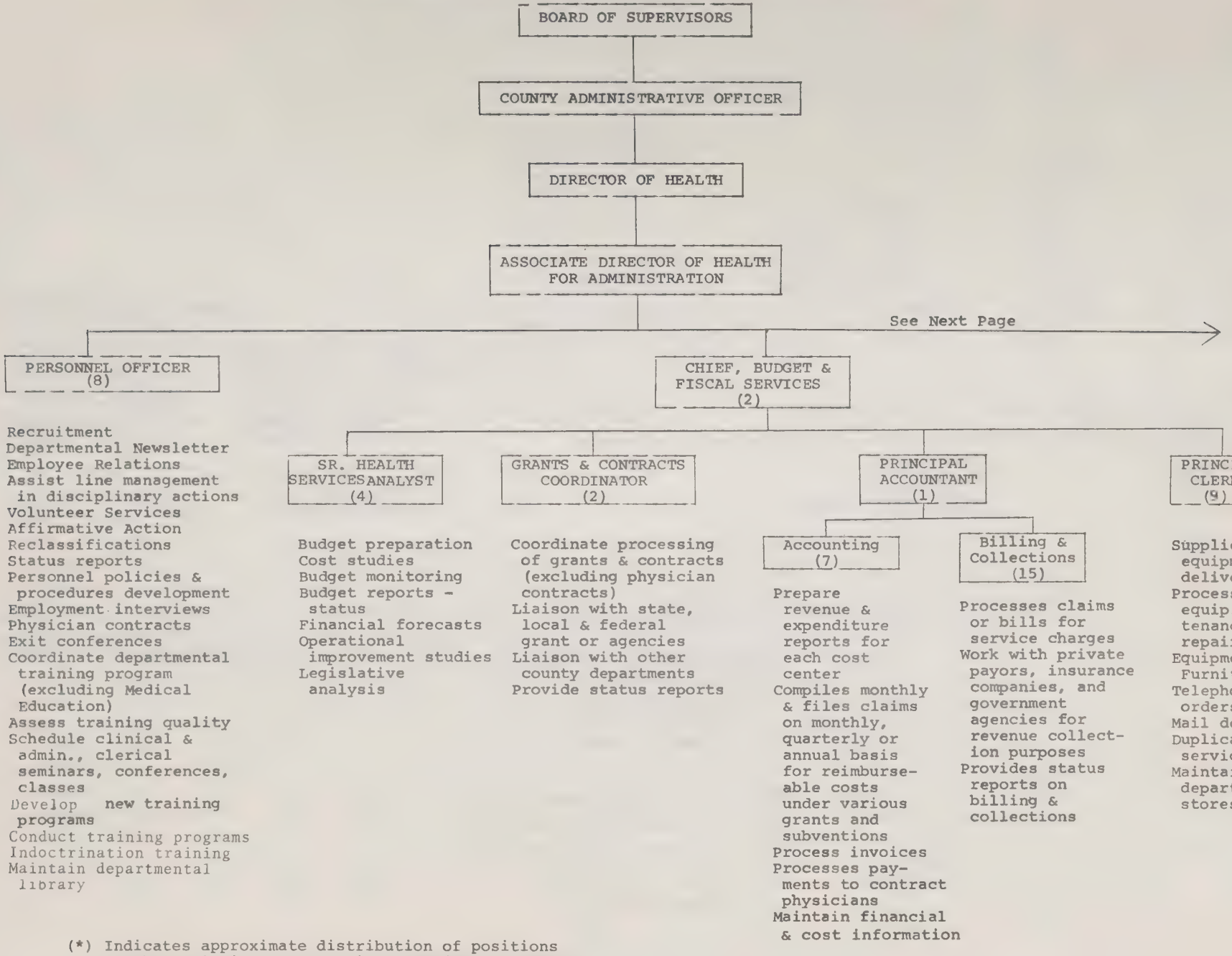
PROPOSED ORGANIZATION OF PUBLIC HEALTH SYSTEM



(*) Indicates approximate distribution of positions to show relative program size. Subject to change.

EXHIBIT II-F

PROPOSED ORGANIZATION OF ADMINISTRATIVE SERVICES SYSTEM



(*) Indicates approximate distribution of positions to show relative program size. Subject to change.

EXHIBIT II-F

PROPOSED ORGANIZATION OF ADMINISTRATIVE SERVICES SYSTEM

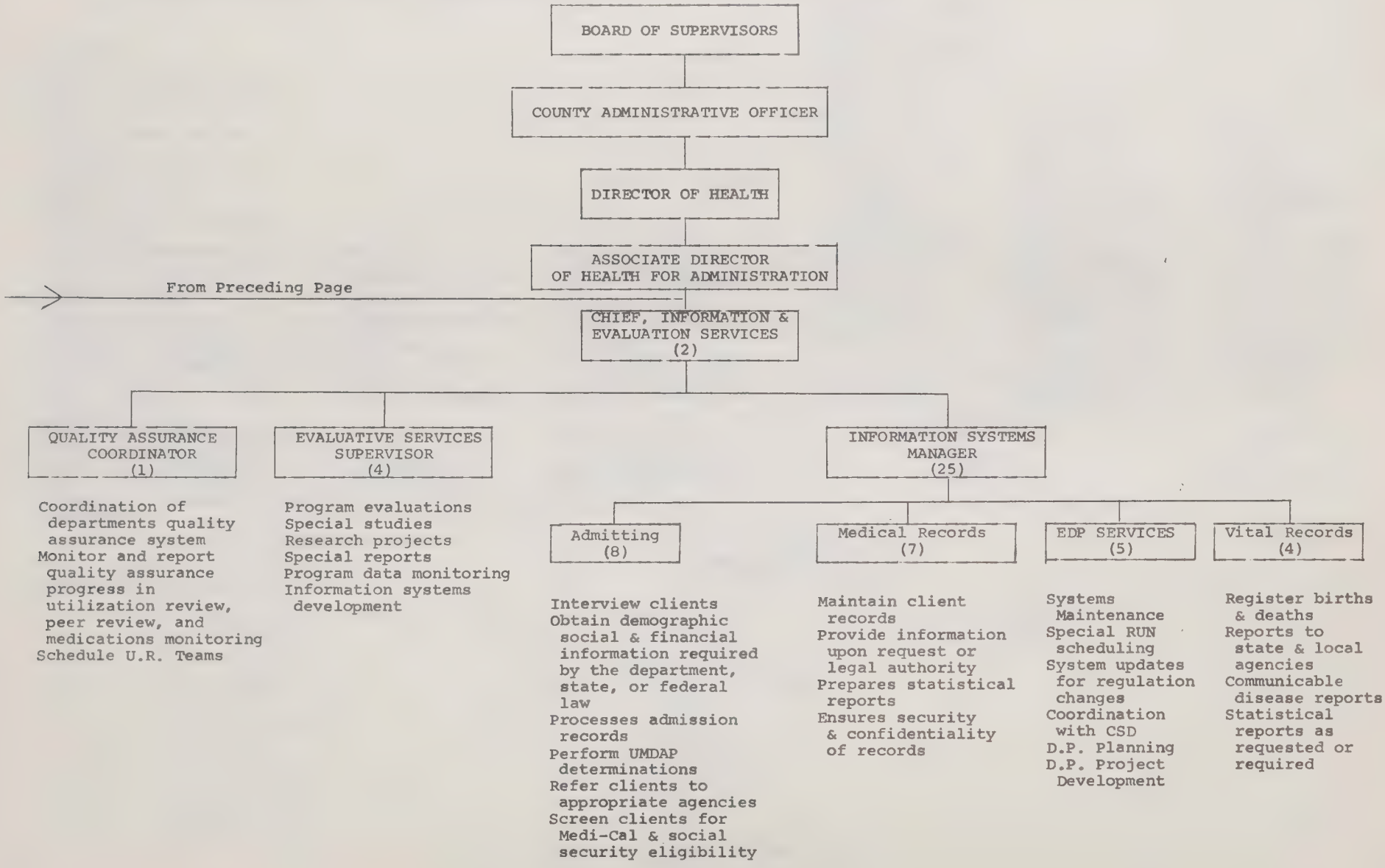


EXHIBIT III

LIST OF RECOMMENDED POSITION ADDTIONS AND DELETIONS

ADDITIONS (To Proposed Organization)	DELETIONS (From Interim Organization)
1.0 Associate Director of Health (Environmental Health)	1.0 Chief Clerk (Environmental Health)
1.0 Associate Director of Health* (Mental Health)	1.0 Deputy Director of Health (Environmental Health)
1.0 Staff Psychiatrist*	1.0 Deputy Director of Health* (Mental Health)
1.0 Patient Advocate** (Mental Health)	1.0 Chief Clerk (Mental Health)
1.0 Service Chief III** (Youth Mental Health)	1.0 Director of Emergency Health* (Mental Health)
1.0 Service Chief I** (Youth Day Treatment)	1.0 Psychiatric Social Work Supervisor (Patient Rights)
1.0 Service Chief III** (Mental Health Inpatient)	2.0 Psychiatric Social Work Supervisor (Youth Mental Health)
1.0 Service Chief III** (Mental Health)	1.0 Supervising Mental Health Nurse
1.0 Service Chief I** (Adult Day Treatment)	1.0 Program Director (Mental Health)
1.0 Service Chief II** (Crisis Mental Health)	1.0 Recreational Therapist (Mental Health)
1.0 Psychiatric Social Worker II (Crisis)	2.0 Psychiatric Social Work Supervisor (Crisis Mental Health)
1.0 Psychiatric Social Worker II (Older Adult)	1.0 Psychiatric Social Work Supervisor (Older Adult)
1.0 Service Chief II** (Mental Health Rehabilitation)	2.0 Psychiatric Social Work Supervisor (Mental Health Rehabilitation)
1.0 Psychiatric Social Worker II (Rehabilitation)	1.0 Psychiatric Social Work Supervisor (Advocare)
1.0 Service Chief I** (Advocare)	1.0 Public Health Physician* (Decentralized System)
1.0 Deputy Health Officer* (Public Health)	2.0 Assistant Director of Public Health Nursing
1.0 Head, Home Health Agency**	1.0 Supervising Public Health Nurse (Home Health Agency)
1.0 Division Chief, Decentralized Health Services** (Public Health)	
1.0 Division Chief, Fulton Mall Health Center, Public Health Services**	
1.0 Division Chief, Health Promotion**	
1.0 Stenographer II (Health Promotion)	
1.0 Associate Director of Health* (Public Health)	

ADDITIONS
(To Proposed Organization)

1.0 Head, Consultation and Education (Health Promotion)
1.0 Assistant Drug Abuse Program Coordinator**
1.0 Personnel Officer**
1.0 Training Officer** (Personnel and Training)
1.0 Chief, Budget and Fiscal Services Division**
1.0 Grants and Contracts Coordinator** (Budget and Fiscal)
1.0 Senior Health Services Program Analyst** (Budget and Fiscal)
2.0 Health Services Program Analyst**
1.0 Chief, Information and Evaluation Services Division**
1.0 Information Systems Manager (Information and Evaluation)
1.0 Quality Assurance Coordinator** (Information and Evaluation)
2.0 Service Chief I (Decentralized System)

34 TOTAL ADDITIONS

*Contract Physician
**Proposed New Classification Title

DELETIONS
(From Interim Organization)

1.0 Deputy Director of Health (Decentralized System)
1.0 Chief Clerk (Decentralized System)
1.0 Public Health Physician* (Public Health)
1.0 Chief Clerk (Public Health System)
1.0 Deputy Director of Health* (Public Health)
1.0 Program Director (Consultation and Education)
1.0 Substance Abuse Director
2.0 Substance Abuse Specialist
1.0 Stenographer/Secretary (Substance Abuse System)
1.0 Program Director (Substance Abuse System)
1.0 Deputy Director of Health (Program Planning and Development)
1.0 Administrative Services Assistant II (Program Planning and Development)
1.0 Research Analyst-Confidential (Program Planning and Development)
1.0 Program Evaluator (Program Planning and Development)
1.0 Program Evaluation Assistant (Program Planning and Development)
1.0 Deputy Director of Health (Administrative Services System)
1.0 Public Health Analyst (Vital Statistics)
1.0 Administrative Services Assistant II (Administrative Services System)
1.0 Administrative Services Assistant I (Personnel)
1.0 Psychiatric Social Work Supervisor (Inservice Training)

DELETIONS
(From Interim Organization)

1.0 Deputy Director of Health (Financial Services System)
1.0 Administrative Services Assistant II (Financial Services System)
1.0 Accountant II - Confidential (Fiscal Section)
1.0 Data Processing Coordinator (EDP Section)
2.0 Psychiatric Social Work Supervisor (Decentralized System)

48 TOTAL DELETIONS

SUMMARY OF NET RECOMMENDED ADDITIONS AND DELETIONS

BY RECOMMENDED ORGANIZATIONAL SYSTEMS

	ADDITIONS	DELETIONS	CHANGE
Environmental Health	1	2	(-1)
Mental Health	14	15	(-1)
Public Health	8	16	(-8)
Administrative Services	10	14	(-4)
Health Promotion Division	3	1	2
TOTAL	36	48	(-12)

2. ADMINISTRATIVE SUPPORT SYSTEMS

Outside of certain functions established in the Director's Office (Public Information, Advisory Boards staff) and positions which provide staff assistance to Associate Directors and program managers (such as Chief Clerks), the Administrative Services, Financial Services, and Program Planning and Development Systems provide the Department's administrative support functions.

This finding examines the placement and proposes realignment of functions and programs currently in each of these three systems, and the Director's Office. Factors considered in the proposed reorganization were legal authorities, type of service offered, and to whom the services were offered. Realignment is proposed for delegating authority over resources commensurate with responsibility, and enhancing the effectiveness of support functions through clearer accountability. The proposed organization also follows the guidelines provided by the Board of Supervisors action of June 12, 1978 which established a single administrative support division within the Department to consolidate related functions and coordinate the direction of staff groups.

The current organization of the three administrative support systems (Administrative Services, Financial Services and Program Planning and Development) is shown in Exhibit I-F. It includes the major organizational units, the full-year-equivalent positions for each, and shows the structural reporting relationships. The functional reporting relationships have varied at times due to the Department's matrix-participative management style which involved the use of committee and task force participation on projects which cut across system lines.

As part of the evaluation of the Department's administrative support functions, we solicited the views of the Department's direct service program management personnel through use of a confidential questionnaire. We surveyed administrative support responsibilities, and considered whether they were appropriately located for greatest effectiveness. We also considered whether authority was sufficient and appropriate to accomplish their assignments. We also considered the input from the managers responsible for administrative support in designing our proposed organization. We received fine cooperation from these personnel in the form of candid and conscientious responses.

The direct service program managers were also asked to elaborate on any matter concerning administrative support which they felt our questionnaire did not sufficiently address. The following summarizes the responses we obtained.

-- The budget process has been an enigma. Many decisions and/or resultant budget changes were made in an arbitrary manner without the opportunity for input. Financial reports need improvement. Accounting review of claims and budgets needs improvement as well as financial reporting systems.

-- The personnel recruitment process is much too slow and often inadequate. Recruitment may take up to four months. There is no method whereby program managers are regularly informed on the status of a particular recruitment request.

-- Administrative support systems sometimes appear to be working against each other or at least not with each other. Many times the responsibility for processing a request seems to end once a request leaves a particular desk. Line program managers are often left with responsibility for following up on requests which are processed in other departments.

-- There has been a tendency for administrative support services to see themselves as an end in themselves rather than a means to an end--the end being service delivery to program clients. Increasing interdepartmental red tape has tended to subordinate clinical services to support services--a reversal of the appropriate order of priorities.

-- There are some services or programs within those three systems that are really not "support" services.

Many of the symptoms or problem areas that managers perceived were also encountered by our study team during examination of other activities within the Department. These symptoms are grouped into major categories and are discussed below.

Fragmented Authorities/Responsibilities

The authorities and responsibilities for a number of administrative support activities are fragmented among the three administrative support systems. The following are highlighted as major examples:

Program Planning and Development (PP&D) has lead responsibility for preparing the Department's budget request. Within this process, the Financial Services System has responsibility to ensure that dollar amounts specified in the request are accurate, and the Administrative Services System reviews levels of personnel, equipment, and supplies for appropriateness. PP&D reviews the narrative portion of the budget request to ensure that its description of goals are consistent with the Department's goals, MBO statements and the Short-Doyle Plan.

Varying or conflicting perspectives among the Deputy Directors of the three support systems about the relative priorities of their budget preparation responsibilities can heighten the difficulties involved in producing a budget request.

Preparation is only one aspect of the budget cycle. Fiscal control and monitoring is the lead responsibility of the Financial Services System. Less direct control responsibilities are shared with the Administrative Services System (recruiting personnel, processing requests for equipment and supplies) and PP&D (activity reviews, program data monitoring). Inadequate coordination of these responsibilities has led to accounting of expenses and revenues into accounts other than as they are budgeted, which hampers monitoring and control.

There is a tremendous amount of information received, processed and generated by the Department's administrative support systems. The major organizational units involved include admitting and electronic data processing services in the Financial Services System, statistical services and client information services in the Administrative Services System, certain data monitoring and development activities in the Program Information and Evaluation Section of PP&D, and the Community Relations (public information) function in the Director's Office.

Much of the information processed by these systems is required or permitted by law and regulation. Title 9, Sections 640-643 of the California Administrative Code, require that community mental health services are responsible for keeping financial, patient service, and statistical records. Sections 1000-1013 of the Health and Safety Code requires that all births and deaths in the County be recorded and also prescribe related information to be recorded. The Statistical Services Section provides this service for Fresno County in conjunction with the County Clerk-Recorder.

There is no overall supervision of the major information generating and processing activities because they are dispersed among the three systems. Consequently, there is little uniformity as to priorities and practices in records handling and maintenance. This fragmented authority may also prevent proper recognition or appreciation of information management problems. The end result may be more costly methods of generating and processing information, or less informative, accurate, or timely reports.

Consolidation of information management functions is recognized by many organizations as vital to their effectiveness because of cost-savings and service improvement potential. The Department is of sufficient size and complexity to warrant consolidation of its major information generating and processing functions.

Processing grants and contracts is another activity for which responsibilities are fragmented among the three administrative support systems. The use of sequential and independent reviews by each system reduced overall control and the potential for expeditiously processing grant applications and some types of contracts through the Department. These activities are discussed in detail in finding 27 on Processing of Grant Applications and finding 28 on Processing Contracts.

All of the above administrative support functions are currently grouped in a manner that diminishes the potential for coordination and control over functions essential to the accomplishment of a task or project. Differing perspectives of importance, priorities, and willingness to contribute among units with various pieces of responsibility for a project can impede the coordination necessary for completion of a project. Under such conditions, it is desirable to consolidate basic functional responsibilities to provide authority consistent with responsibility, as well as to pinpoint management accountability for carrying out projects and assignments.

Some Administrative Support Services Should be Realigned With Public Health or Mental Health Systems

Section 5751.2 of the Welfare and Institutions Code says the local mental health service administrative support includes: 1) all administrative functions such as personnel, accounting, budgeting, and patients accounts; 2) all life support functions such as food services, facility maintenance, and patient supplies; and 3) all other business and security functions.

There are some services provided under the three administrative support systems, which by law, type of service, or type of client, would not appear to be classified as an administrative support service. These services are identified below by system.

Program Planning and Development System - Consultation, Education and Nutrition. These services are provided to Department of Health staff as support to treatment, and to community interest organizations, schools, and other human services agencies. Mental Health Consultation and Education also operates the Primary Mental Health Project. This project is concerned with inservice training of teachers and principals in child mental health, parent education, education of high school students for young adulthood and parenting, helping grade school children at risk of eventual emotional adjustment problems, and delinquency prevention.

Mental health consultation and education services are required elements in the County's Short-Doyle Plan, under Section 5651(c) of the Welfare and Institutions Code. Sections 102, 208, and 1111 of the Health and Safety Code and Title 17, Section 1303 of the California Administrative Code require counties to provide public health education and nutrition services.

Provision of mental health consultation and education services and operation of the Primary Mental Health Project by the Program Planning and Development System (PP&D) are done under written agreement between the system Deputy Director and the Local Mental Health Director.

With the advent of the interim organization after July 1, 1978, the Department recognized that under their management structure, a Deputy Director in charge of a particular system may not report to the duly appointed Health Officer or Mental Health Director ultimately responsible for compliance with the laws or regulations governing mental and public health services. Written agreements were executed between appropriate system Deputy Directors and the County Health Officer and Local Mental Health Director. Examples of services for which written agreements exist include the Director of Public Health Nursing in PP&D, and the Public Health Laboratory and Statistical Services in Administrative Services.

Consultation, education and nutrition services are not administrative services. A detailed discussion on the placement of these services appears in finding 7 on Organizing Resources for Health Promotion.

Program Planning and Development System - Director of Public Health Nursing. While administrative coordination of the development and execution of the quality assurance system is necessary, the use of the Director of Public Health Nursing to fill this role is not entirely within the spirit of the law which mandates the position. The role of the Director of Public Health Nursing, discussed at length in finding 3 is supposed to be primarily supervisory or management in nature, reporting directly to the Health Officer (California Administrative Code Section 1250 and 1253).

Administrative Services System - Public Health Laboratory. The services performed by the Public Health Laboratory are clinical rather than administrative. As such, they should be appropriately aligned within the public health organization to ensure competent medical program management. Sections 208,1000, and 1102 of the Health and Safety Code create the Public Health Laboratory and a Director of the Public Health Laboratory. A review of these sections leads us to believe this function should report through appropriate channels to the Health Officer.

Financial Services System - Crippled Children's Services. Crippled Children's Services conducts eligibility determination and provides case management and physical therapy services. Its clients are children and/or parents of children with neurologically, orthopedically, or other physically disabling or crippling conditions. While we recognize a close working relationship with Financial Services due to the need for payment and financial eligibility information, the thrust of this program is providing a direct health service through case management and physical therapy. It is not an administrative support service.

Placement of the above services under the direction of administrative support managers does not give clinical program managers control over functions which are important if not essential to the accomplishment of their basic mission. Nor does it supply appropriate clinical advocacy, supervision, and coordination for those clinical units located in administrative support systems.

Management responsibilities should be distributed in a way to provide effective span of control and yet be grouped to give managers control over all functions essential to the accomplishment of their basic mission.

RECOMMENDATION

3. That the Board of Supervisors approve the proposed reorganization of administrative support services in the Department of Health as depicted in Exhibit II-F.

AUDITOR-CONTROLLER COMMENT

Administrative Services is the system responsible for the financial and fiscal functions for the Health Department. One of the main objectives of this unit is to assure accurate and timely financial and program management information. This information is provided to Health Department management and a multitude of Federal, State, local, and private agencies. In view of the responsibility of this unit, our office recommends that the proposed organizational structure be reevaluated in terms of the financial emphasis. We feel the following functions and/or classifications require review:

- Senior Health Services Analyst - This position is responsible for the preparation of cost studies, budgets, and financial forecasts. These functions require a comprehensive knowledge and expertise in the areas of General Accounting, Governmental Accounting and Cost Accounting in addition to a thorough understanding of the Fresno County budget process and the Financial Management Information System. The specifications for this position, we believe, are more in line with the Accountant classification series.

- Principal Clerk - The position of Principal Clerk should not be reflected on the same level as that of the Principal Accountant. This position, due to the degree of accounting coordination required, should more properly report to the Principal Accountant. The close financial association of the Principal Clerk's areas of responsibility to accounting may result in improved document processing, improved accounting information to program areas, and perhaps more uniform and consistent departmental expenditure processing procedures.

- Personnel Officer - Certain activities such as recruitment, reclassifications, and employee relations are duplications of County Personnel services.

CAO RESPONSE

The proposed organizational structure has already been designed to consider the important financial emphasis placed upon the proposed Administrative Services System. All financial support functions are consolidated under a high level manager, the Chief of the Budget and Fiscal Services Division, to form a comprehensive cluster of financial support staff. We believe this is a significant modification to the existing organization and represents an appropriate organizational recognition of the importance of these functions.

The proposed Senior Health Services Program Analyst may, but not necessarily should, be classified within the Accountant classification series. We have recommended a Principal Accountant within the proposed Budget and Fiscal Services Division to provide professional accounting expertise and supervision for the Department. We view that position as responsible for the critical financial management functions of classifying and accumulating expenditures and revenues, processing invoices, preparing claims, collecting accounts receivable, and preparing related reports. This position must have technical accounting skills to manage these functions and ensure the integrity, accuracy and consistency of financial records and reports.

The Senior Health Services Program Analyst position must be conversant with government finance, but need not necessarily possess technical accounting skills to discharge its responsibilities. They include managing the budget preparation process, analyzing expenditure and revenue trends and preparing forecasts, managing budget administration and controls, and conducting administrative and operational studies to promote efficiency. These duties call for skills other than technical accounting expertise including an analytical ability, an understanding of administrative mehtods, financial management ability, and written and oral communications skills.

We view the responsibilities of the Principal Clerk as carrying out routine general services under structured procedures specified by the Chief, Budget and Fiscal Services with the assistance of the Principal Accountant. We feel it is important for internal control to separate the accounting function from units such as general services that generate accounting records of financial transactions of purchasing, inventory, and distribution.

We do not view the responsibilities of the proposed Personnel Officer as a duplication of the functions of the Personnel Management Division. In departments as large as Health, there are economies of scale in functions such as personnel, accounting, or budgeting which permit an economical decentralization of staff resources. Work between the department specialist and the central staff group counterpart, such as Personnel Management, can be distributed without duplication. We expect relief of central staff workload, and better internal department responsiveness to the needs of program managers.

3. DIRECTOR OF PUBLIC HEALTH NURSING

The Department employs a Director of Public Health Nursing within the Program Planning and Development System (PP&D). This finding examines the role of that position as it exists currently in the Department.

Section 1250, Article 1, Chapter 3 of the California Administrative Code states that the Health Officer shall direct the public health service. Section 1253 requires that, within the organization of the local public health service,

> "There shall be a public health nursing staff under the supervision of a director of public health nursing, and such additional supervisors, who are qualified as public health nurses, necessary to provide effective service."

Section 1301, Article 3 of the same Code, prescribes the qualifications of the Director of Public Health Nursing:

> "The Director of Public Health Nursing shall be a public health nurse who has:
>
> 1) Completed a baccalaureate program of study in public health nursing accredited by the National League for Nursing and has had three years of progressively responsible experience in public health nursing; or

2) A Masters Degree with preparation in nursing administration, supervision, or consultation from a program accredited by the National League for Nursing or the American Public Health Association and at least three years or progressively responsible experience in public health nursing."

The above Administrative Code references in part enact the provisions of Section 1130 of the Health and Safety Code requiring standards for organization and the qualifications of technical personnel in the local public health service, which are conditions under which the County receives State aid for local health administration. In 1977-78, this aid totalled $125,952, and is estimated to be $125,000 in 1978-79.

The class specifications for the Director of Public Health Nursing for the Fresno County Health Department were revised in July, 1977, and appear as Exhibit IV. Generally, it provides that the duties of this position include providing functional guidance and direction for nursing activities in departmental programs; development and maintenance of a multi-disciplinary quality assurance program; liaison with Federal, State and local agencies and organizations; and participation in the development of career training programs for nursing personnel.

In addition, a statement of responsibilities of the Director of Public Health Nursing was developed by the incumbent with collaboration and approval of the Department's Executive Staff Committee. (This is one of only a few instances we have yet found in the Department where management has developed or endorsed a specific list of duties to guide an employee in meeting management's expectations of employee performance).

This role entails:

1. Coordination of quality assurance activities in the Department of Health. Quality assurance refers to activities directed at the improvement of clinical practice in health programs.

2. Meeting with nursing supervisors, Assistant Directors of Public Health Nursing, and nursing staff to assure quality and prevent duplication within the Department.

3. Development of a professional peer group composed of public health and mental health nurses to deal with nursing standards, issues, or practices.

4. Keep nursing staff and other departmental staff informed of legislation affecting nursing.

5. Identify training needs for nurses in coordination with inservice training staff.

6. Liaison to various health agencies.

7. Serving as a resource to community groups involved in community health development.

8. Keeping the Director of Health informed of potential problem areas, new developments affecting nursing, and relate information from the Director to nurses.

9. Assistance to nursing supervisors and Assistant Directors of Public Health Nursing with hiring of public health nurses.

10. Participation in formulating agency policies relating to or affecting nursing services.

11. Participation in planning, implementing and evaluating nursing practices to assure safe, efficient, therapeutic and effective nursing care.

We interviewed the Director of Public Health Nursing to find out the extent to which she has been able to carry out the above duties. She indicates that since her appointment to the position in February, 1978, she has only been able to properly perform quality assurance responsibilities. She estimates about 90 percent of her time is spent in developing and coordination quality assurance, with the remaining 10 percent of her time devoted to her other duties (numbers 2 - 11). To date, nearly all of the quality assurance development has involved mental health services. This occurred because of utilization review requirements established for mental health inpatient and outpatient services as a prerequisite to State reimbursement of local costs. Quality assurance is discussed in detail in finding 15.

This information led the study team to the following concerns about the use of the position of the Director of Public Health Nursing:

1. Its organizational placement within an administrative support system (PP&D) rather than in public health as specified in the California Administrative Code.

2. The use of the Director of Public Health Nursing in developing mental health quality assurance activities which does not fully utilize her expertise.

As presently assigned, the position cannot function as a supervisor of a direct service. While we recognize that the original merger of the Department has dispersed a number of nursing functions among several programs, the intent of the law was for this position to directly provide leadership in a public health capacity that would utilize her training and experience to best advantage. Since the July 1, 1978 interim changes to the Department's organization, the position has also been removed from the indirect supervision of the Health Officer (formerly Director of Health) since PP&D does not report to the Health Officer.

The heavy involvement of the Director of Public Health Nursing to date in quality assurance program development in mental health services has been to the near exclusion of public health nursing duties. Of the duties other than quality assurance, the following have had little or no investment of time by the Director of Public Health Nursing:

-- Liaison with nursing supervisors to facilitate nursing activities--average of two hours per month has been spent in this activity. Since November 1, 1978, this has increased.

-- Development of professional peer groups to deal with nursing issues and standards.

-- Assistance to nursing supervisors with hiring of public health nurses and serve as a resource person to nurses interested in working for the Department of Health.

These duties, as well as her involvement in formulating policies related to public health nursing services and programs, should have greater priority within the role of the Director of Public Health Nursing.

RECOMMENDATIONS

4. That the Director of Public Health Nursing be transferred from the Program Planning and Development System to the Public Health System and report directly to the Health Officer.

5. That the Department shift the responsibilities of the Director of Public Health Nursing toward public health activities, as shown in Exhibit V, and reflect these changes in the classification specifications, duty statement, and actual assignments of the position. Quality assurance coordination responsibilities are recommended placed in the Administrative Services System in finding 15 on Quality Assurance.

6. That the Director of Public Health Nursing report directly to the Health Officer, providing clinical staff support and indirect nursing supervision in the Public Health System. This organizational placement and indirect supervision role over the nursing discipline will preserve those advantages of interdisciplinary coordination, team integration and interaction with various services, and accountability for program efficiency and effectiveness to be gained from the continued program-oriented organization of public health services. We believe this indirect supervisory role would meet the intent of the law that the Director of Public Health Nursing supervise public health nurses. She would be responsible for consulting on the quality and coordination of nursing and other clinical resources, and advising the Health Officer on the provision of clinical public health services including nursing.

7. That the Director of Public Health Nursing retain, on a part-time basis, the responsibilities of monitoring issues and resolving problems of concern to the public health nursing discipline throughout the Department. These responsibilities comprise duties 3 - 14 on Exhibit V. This provision is intended to fill the need for a focal point of nursing concern and representation, coordinate nurses in urban-rural settings, and develop protocols and materials to further develop the team delivery concept. As such, the Director of Public Health Nursing must have access and be accessible in a staff capacity to all Public Health Nurses in the Department.

8. That the Department of Health develop responsibility statements for all of its management personnel to make expectations clearer, and as a reminder to direct attention to all aspects of their job.

EXHIBIT IV

FRESNO COUNTY
Revised
7-28-77

DIRECTOR OF PUBLIC HEALTH NURSING

DEFINITION:

Under general direction, provides functional guidance and direction for nursing activities in departmental programs; develops and maintains a multi-disciplinary quality assurance program; acts as a liaison with local, state and national organizations; participates in the development of career training programs for nursing personnel; and performs related work as required.

DISTINGUISHING CHARACTERISTICS:

The Department of Health has as its objective the physical, mental and social well-being of County residents. To accomplish this, the department provides a comprehensive multi-disciplinary system of health services through facilities decentralized into geographic areas of greatest need.

Within this structure, the Director of Public Health Nursing, reporting to a Deputy Director of Health, is delegated the following responsibilities:

A. Providing functional guidance and direction for nursing activities in departmental programs. These programs are primarily oriented to providing community health services with focus upon concepts of prevention, treatment, education and rehabilitation.

B. Developing and maintaining a multi-disciplinary quality assurance program emphasizing personal health care delivery systems.

C. Acting as a liaison with local, state and national organizations.

D. Participating in the development of career training programs for nursing personnel. These include continuing education programs and specialized nursing programs.

The incumbent of this position must possess strong oral and written communication skills; the ability to relate well to management and employees at all levels and with the public; good judgement, a high degree of maturity and integrity; and strong administrative skills.

EXAMPLES OF DUTIES:

1. Participates in administrative planning, implementation and policy direction of community health services.

2. Develops and maintains a multi-disciplinary quality assurance program for the department.

3, Participates in departmental evaluation of community health service programs.

4. Consults with in-service training staff regarding career development activities for nursing staff such as continuing education programs and specialized nursing programs.

DIRECTOR OF PUBLIC HEALTH NURSING (Cont'd)

EXAMPLES OF DUTIES: (Cont'd)

5. Promotes community health action based on Department of Health objectives and provides technical advice and consultation to committees, school personnel and community groups.

6. Plans with other agencies to develop the delivery of available community nursing services to hospitals, clinics, schools, industries and homes.

7. Collaborates with other professions and citizen groups in studying, planning and implementing community health programs.

8. Supervises and conducts research in nursing and other aspects of community health services.

MINIMUM QUALIFICATIONS:

Either:	Education:	A master's degree in nursing administration, public health nursing or a related field.
	Experience:	Three years of progressively responsible public health nursing experience.
Or:	Education:	A bachelor's degree in nursing administration, public health nursing or a related field.
	Experience:	Four years of progressively responsible public health nursing experience.
And:	License:	Valid California Public Health Nurse Certificate.

JCN: 1310

EXHIBIT V

PROPOSED ROLE OF NURSING DIRECTOR

1. Advise the Health Officer on the quality and coordination of clinical resources including nursing, and on the delivery of clinical public health services in the Department of Health.

2. Consult on quality assurance activities for clinical services in the Public Health System of the Department of Health.

3. Be accessible to and meet with nursing supervisors and staff individually and jointly to facilitate nursing activities to assure quality and prevent duplication within the Department.

4. Keep nursing staff and other Department of Health staff informed of legislation which affects nursing, and provide professional advocacy at the State level.

5. Assist in identifying needs for inservice training for nurses in coordination with inservice training staff.

6. Serve as lisison to various health agencies and health providers, such as:

    a. California State University at Fresno
    b. California Nurses Association (excluding bargaining activities)
    c. Health Consortium
    d. California Conference of Local Health Department Nursing Directors
    e. National League for Nursing
    f. Health Systems Agency

7. Act as resource person to community groups involved in community development as indicated.

8. Keep the Director of Health and the Health Officer informed of potential problems and/or new developments which may affect nursing and relate information from the Director's Office and Health Officer to nurses.

9. Serve as resource person to nurses who are interested in working for the Department of Health.

10. Participate in formulating agency policies when they affect or are related to nursing services.

11. Participate in planning, implementing, and evaluating nursing practices to assure safe, efficient, therapeutic and effective nursing care.

12. Work with public health division chiefs and nursing supervisors to develop a plan for coverage of nursing services.

13. Work with the Director of Health and all disciplines to promote a philosophy of care which sees the needs of the total patient.

14. Consult with nurse practitioners in defining distinctions in roles between practitioners and nurses.

4. ORGANIZATIONAL PLACEMENT OF AIR QUALITY PROGRAM

Fresno County has the fifth largest Air Pollution Control District (APCD) staff in the State with 16.4 budgeted positions and 14.4 filled positions. Our review has encountered several arguments for having the Health Department's Air Quality staff report higher in the Department or County organization. The Air Quality staff is the group within the Environmental Health System of the County Department of Health which operates the County's APCD on a fee for service reimbursement basis (see finding 18 on Financial Management of the APCD).

Layers of Management

There are a number of management layers between the Board of Supervisors, sitting as the Air Pollution Control Board, and the Supervising Sanitarian and Senior Environmental Engineer who direct the day-to-day operations of the APCD. Exhibit I-A shows that in the 1977-78 organization, intermediate levels included an Assitant Director of Environmental Health, the Director of Environmental Health, and Director of Health who has also been designated the statutory Air Pollution Control Officer of the District, and the County Administrative Officer. Since the adoption of the proposed organization June 12, 1978, and its implementation with the appointment of an acting Director July 1, 1978, the County Health Officer has been added to this chain of command due to statutory requirements and as depicted in Exhibit I-C.

This degree of management layering affects the amount of interest and involvement each of these management personnel can be expected to invest in the air program. It tends to fragment management attention to the program, or foster top management inattention, particularly at the level of Air Pollution Control Officer (Department Director) due to the program's remoteness from the Department's top decision-making level. The importance of this management scrutiny is illustrated by the far reaching significance of the Air Quality Maintenance Plan/Non-Attainment Plan (AQMP/NAP) which recently underwent review by local government agencies.

This structure probably obscures management's scrutiny of the air program's priorities, effectiveness, and planning efforts. It also obscures placement of accountability for the day-to-day success or failure of the program. The physical separation of the offices of the managers involved has no doubt aggravated these problems. Nevertheless, air program staff have worked aggressively to help the program develop and meet Federal and State mandates and deadlines.

Management layering also can result in delays to processing District grant applications and reports due to the review time taken by remote managers out of proportion to the size of the program. Unnecessary review levels can prolong the decision-making process and slow implementation of program elements. Each layer of management in the chain of command must also place the air program in competition with other programs for their limited time and attention. Because of air program complexity, it is also very difficult for these managers to grasp all but the most succinct reports and proposals since they can only deal with the program on a part-time basis. This is increasingly the case with each higher level from Assistant Director of Environmental Health on up.

This situation also promotes considerable de facto, non-explicit delegation of authority to the Supervising Sanitarian and Senior Environmental Engineer because they are the program's only full-time managers. They are heavily involved in overall program management issues such as Zero Base Budgeting (ZBB), Air Resources Board (ARB) and Environmental Protection Agency (EPA) liaison, AQMP/NAP development, Basin Control Council planning and model rule review, contract County liaison, other inter-governmental relations, and public relations. This reduces the time they have for important functions of internal program supervision and support to the field sanitarians and technical staff. This has further resulted in over assignment of responsibility to veteran line staff who have less time remaining for their primary field work duties.

However, largely through the efforts of the staff, the program appears to be operating successfully within today's technology, legal mandates and authority. This view was also expressed by a report of the Local Environmental Health Program Section of the State Department of Health in a 1977-78 evaluation of Fresno County Environmental Health programs. Problems our study encountered in the District's financial management can be attributed to the separation of responsibilities among the Department's administrative support systems rather than to the District's chain of command. The organization of administrative support systems is addressed in finding 2.

Program Independence

The complexity of the Air Quality Program has permitted the program staff to operate somewhat independently of and isolated from the Department's top management. It is relatively unique among environmental health programs because of its physical sciences orientation and the engineering component that is required for evaluating and issuing Authorities to Construct and Permits to Operate. Instrumentation for air quality monitoring is another technical

component which sets the program apart from most other programs of the Environmental Health System. The law requires formal APCD Hearing Board action on upset-breakdowns and start-ups, and other issues, which rely on technical evaluations and consultation.

This program isolation is also promoted by the level of subvention of the program by the ARB and EPA. Their 1977-78 grant payments of $79,955 and $114,940 respectively accounted for 44.9 percent of the District's revenue of $433,423. Total non-General Fund financial support of the District in 1977-78 totaled 55.2 percent of operating costs. Other environmental health programs are primarily supported by the County General Fund which therefore makes them more vulnerable to budget curtailments during periods of declining general revenues.

The EPA and ARB propose work goals for the District as conditions to receipt of grant funds. Many of these goals are negotiable. Top management delegates the negotiations to the Air Quality staff without setting County policy priorities for negotiation and selection of program work goals.

There are potential Federal revenue sanctions associated with District performance under the AQMP/NAP as well as the subvention work plan goals. Top management has not monitored District activities closely enough to ensure it met its goal commitments to avoid sanctions. However, no sanctions have been imposed.

Nevertheless, all environmental health programs are somewhat independent of one another and in the clientele they serve, the statutes and regulations they enforce, and in the State agencies with which they interrelate. To remove the air program from Environmental Health solely because of its independence would logically argue for the dissolution of Environmental Health as a collection of preventive health programs.

Working Relationship to Environmental Health

We also encountered the view that the air program is too specialized to be managed within the broader Environmental Health organization context. However, a distinct advantage of this organizational placement is the sharing of clerical staff to cover absences and workload peaks.

Nevertheless, there is little day-to-day interaction between the air program and other Environmental Health programs for the routine conduct of District business. Any enforcement support APCD personnel receive from other Environmental Health personnel is incidental to the overall program.

However, the biological effects of air pollution on the health of the population and ecosystems are recognized as its major detrimental impact. The physical effects of air pollution, such as visibility impairment and deterioration of paint and other materials, receive proportionately less attention. From this standpoint, the air program can benefit from continuing its association with Environmental Health. There it can be supported, represented, advocated, and guided by managers who are more directly concerned with the effects of environmental factors on health quality and the transmission of disease.

There are two shortcomings to the organizational linkage of the Air Quality Program with Environmental Health. One is that it promotes turnover as sanitarians transfer in from and out to other Environmental Health programs. It takes about six months to train a sanitarian for air program surveillance and enforcement work. This makes staff continuity especially important to the effectiveness of the program. Fortunately, turnover has not been a major problem, though recruitment as the program has expanded has tended to draw from the ranks of sanitarians from other Environmental Health programs.

The other shortcoming is that the exclusive use of registered sanitarians for enforcement work reduces the County's opportunity to recruit experienced and already qualified personnel to fill vacancies in the air program. Many county air pollution control districts, such as Sacramento, Kern, and San Joaquin, utilize air pollution specialist classifications, and recruit persons with physical or biological science backgrounds who do not necessarily have training or experience as sanitarians. This specialization permits those air pollution control districts to recruit on the outside for persons who are already trained in air quality programs without having to qualify them as sanitarians. This substantially reduces the orientation time of new APCD employees before they become effective.

Sanitarians do have a useful background to offer APCD operations besides their disease prevention and health knowledge. Their program organization experience was especially important during formative years of the District. They are also conscious of the importance of public relations and are skillful in using persuasion and educational techniques to promote compliance with regulations. They know when conditions justify sanctions to enforce regulations as a last resort.

The classifications used for Fresno County APCD engineers are "Environmental Engineer" and "Senior Environmental Engineer." They were developed to anticipate the need for engineering and technical assistance to other Environmental Health programs. That anticipated requirement has not materialized. Consequently, more air pollution

specialized classifications could be utilized and would assist in recruiting experienced air pollution engineers for the Fresno County APCD. Effective July 1, 1978, Environmental Health Technicians utilized in the air program were reclassified to Air Pollution Instrument Technicians to obtain similar benefits.

Alternative Organizational Placements

In evaluating the County's organization placement options for the air program, we identified three basic alternatives: reporting to the Department Head; separate department status; or continuing to report to Environmental Health with improvements in the current pattern. We concluded the third alternative was the most desirable because it mitigated management layering, recognized the program's independence, and enjoys the benefits of its health affiliations and orientation without the negative side effects of the other alternatives. Changing conditions in the air pollution field could require further reorganization in the near future, but not necessarily. The alternatives discussed below can be reconsidered at the appropriate time. In the meantime, the Health Department can administratively reform and streamline what is in place now, and build upon what has been a successful program so that it can better adapt to the increasing demands placed on it.

Alternative of Reporting Directly to the Department Head

One or both of the two first line supervisory APCD staff or an Assistant Director of Environmental Health (as the Assistant Air Pollution Control Officer) could report directly to the Department Head. A new position might be created to serve as the Assistant Air Pollution Control Officer, depending on the competing demands for the time of the two existing Assistant Directors of Environmental Health. Counties which use this alternative (but with minor variations) are Tulare, Kern and Sacramento.

This approach would offer substantial relief from the management layering problem short of increasing the number of County departments reporting to the Board of Supervisors. It also recognizes the program's complexity and isolation from Environmental Health, including its dependence on rules promulgated by the Basin Control Council. The Basin Control Council is the multi-county APCD coordinating agency for the San Joaquin Valley.

If trends continue, the air program, through existing and proposed State and Federal mandates, will intrude more deeply into sensitive policy areas in the years ahead. They already are involved in issues which include implications for land use, transportation, and mobile emissions that go well beyond existing controls on new and existing

stationary sources. These developments will demand increased top management attention as new control proposals emerge that require high policy decisions. This alternative could become more attractive as these trends continue.

Because of the background of the incumbent staff, the possible separation of the air program from Environmental Health would not immediately result in disassociation from management with more direct concern for environmental factors on health quality. However, in the long term, this approach could promote a shift in emphasis from health promotion to engineering and enforcement interests.

More immediately, this alternative would utilize the Director of Health as a second level manager. This would either hamper his ability to function as the chief executive for all programs of the Department by placing disproportionate demands on his time, or the program would receive insufficient attention from him. This is our principal objection to this alternative in view of the extremely wide variety of programs and services delivered by the Department of Health.

Because of competing demands upon the time of the two existing Assistant Directors of Environmental Health, a new position might be needed to serve as the Assistant Air Pollution Control Officer. In reporting directly to the Department Head, the Assistant Air Pollution Control Officer would not only have his program administration responsibilities, but the oversight duties now performed by upper management layers. The remedy would result in added cost.

Alternative of Separate Department Status for the Air Program

The air program could be separate from the Department of Health because air is more closely associated with regional, State and Federal policies than with local policy. Presumably this would permit the APCD to be more adaptable to inter-County coordination needs. Counties which have organizations similar to this alternative include San Diego, Stanislaus, Ventura and the counties of San Benito, Santa Cruz and Monterey which have a tri-county APCD.

Air pollution is, among environmental health issues, most clearly a basinwide (multi-county) problem requiring consistent control measures across county lines. Other environmental health programs are defined primarily by broad State mandates, with service levels and enforcement policies largely determined by local option. However, some environmental health programs such as solid waste, water quality and milk inspection also have inter-county health impact. They haven't experienced as much State and Federal leadership in developing coordinated efforts or program monitoring and intervention as is found in air quality.

Air program coordination in the San Joaquin Valley is accomplished through a Basin Control Council (BCC). This organization was originally formed from the Air Resources Committee of the San Joaquin Valley Supervisors Association in 1971. Health and Safety Code Section 40900 requires all air basins with two or more APCD's to have a basinwide air pollution control council. Participants in our basin council are the following Valley counties: Kern, Kings, Tulare, Fresno, Madera, Merced, San Joaquin, and Stanislaus. Under § 39802, Health and Safety Code, Fresno County is party to an enforceable agreement with these counties that requires the BCC to review model rules and adopt uniform rules for all the air pollution control districts of the entire basin.

These coordination mechanisms have so far been successful in meeting the needs for consistent standards among air pollution control districts in the Valley, though the vigor of enforcement efforts still varies. Nevertheless, the BCC can be the forerunner of regionalization of air quality efforts if this should become necessary. In the meantime, retention of the Air Quality Program with Fresno's Environmental Health System does not prevent regionalization if eventually required, nor has it impeded current coordination efforts of the BCC.

This alternative also has the long-range fault of removing the air program from health-oriented management with the possible consequent shift in emphasis to engineering and enforcement. It would also add to the number of departments the County Administrative Office and Board of Supervisors must supervise, and probably increase administrative costs to sustain an independent department operation which would be relatively small by Fresno County standards.

Alternative of Reform of the Present Organizational Pattern is Recommended

The number of management layers can be reduced as we recommend in this finding and in finding 6 on Organizatioal Placement of Environmental Health. Management scrutiny of the program can be increased by lowering the level of the Air Pollution Control Officer designation and consolidating program supervision responsibilities. A subalternative to the recommended means of consolidating program supervision would be to create an additional position of Assistant Director of Environmental Health to serve as Assistant Air Pollution Control Officer. The current Assistant Director, who spends 40 percent time on the air program, would be freed to devote more time to Environmental Health's other 22 programs. However, in view of declining General Fund financing, this approach would make less funding available for direct service positions. The second existing Assistant Director position was also partly justified as

an Air Program Manager originally. As funding for non-air Environmental Health programs declines, it is likely the size of those programs and the need for the second Assistant Director's attention to them will also decline.

Coupled with the benefits cited above for retaining the air program within the Environmental Health organization, the following changes should allow the Air Pollution Control District to be successfully administered by Environmental Health for at least the new few years.

RECOMMENDATIONS

9. That the Air Pollution Control District continue, for at least the next two to three years, to be administered by the Environmental Health System of the Department of Health. This organizational placement should be evaluated in a few years to see if adjustments are needed due to changing conditions.

10. That the recommended position of Associate Director of Health for Environmental Health be designated the Air Pollution Control Officer, reporting through appropriate administrative channels including the Director of Health and the County Administrative Officer to the Air Pollution Control Board.

11. That the office of the Air Pollution Control Officer be located in the same facility as the air quality staff at the earliest possible date.

12. That an Assistant Director of Environmental Health who has been program director for developing the AQMP/NAP, be given the functional title of Assistant Air Pollution Control Officer. He should increase the amount of his time from the current 40 percent level spent on air quality administration and the AQMP to that level necessary to serve as the principal program manager of the APCD. This consolidation of responsibility is needed because of the unique complexity, financing, and inter-governmental relations components of the program. Present staff have done well under adverse conditions and should be given this added help.

13. That the Supervising Sanitarian and Senior Environmental Engineer be relieved by the Assistant Air Pollution Control Officer of substantial portions of their program management responsibilities to permit them to spend more time in the important function of direct supervision of field services. The Assistant Air Pollution Control Officer should assume primary responsibility for budget development,

administration and control; grant application development and administration; district work plan development and monitoring, and evaluation; inter-governmental relations; and preparation of APCD presentations to Health Department management, the County Administrative Office, the Air Pollution Control Hearing Board, and the Air Pollution Control Board.

14. That sanitarian positions in the Air Quality Program be placed in combination with a new classification series of Air Pollution Specialist. This will give the APCD the option to recruit qualified, experienced air pollution personnel from outside the County who need not meet the registration requirement for sanitarians. The minimum qualifying training and experience for Air Pollution Specialists should include sanitarians as a principal career pool resource to help ensure a continued health orientation to the program.

15. Enforcement and surveillance sanitarian positions should gradually be phased over to Air Pollution Specialists to promote staff continuity and stability.

16. Environmental Engineers should be reclassified to Air Pollution Engineer titles.

5. RESPONSIBILITIES OF SERVICE CHIEFS, FIRST LINE SUPERVISORS, AND LEADMAN THERAPIST POSITIONS

Currently, the Mental Health System is composed of eight programs or services. These include Mentally Disordered Offenders, Inpatient, Crisis, Older Adult, Adult Day Treatment, Rehabilitation, Advocare, and Facilities Consultation. In addition, the Youth Mental Health Services Program is currently under the Public Health System; the Mental Health Outreach Program is under the Decentralized Health System; and the physician director of the Psychiatric Residency Program reports to the Director of Health. Youth Services mental health programs are composed of two main programs--Youth Outpatient and Day Treatment. These organizational relationships are shown on Exhibits I-A and I-B.

The Associate Directors of Mental Health and Public Health designate a program manager called a "service chief" for each of the eight mental health programs under the mental health system, and to each of the two mental health programs and outreach services under the public health system, respectively. This position is responsible for supervising

employees ranging in number from 3 to 65 depending upon the type of program and number of clients served. There are also first line supervisory or leadman positions between service chiefs and line employees in the larger services.

The common denominator among duties of the service chiefs is their administrative responsibility for directing and coordinating one program and a clinical responsibility to see that physician patient care instructions are properly interpreted and carried out. These responsibilities include selecting, assigning, and supervising lower professional and sub-professional staff; employee scheduling; budget preparation and monitoring; and reviewing employee performance and developing periodic evaluations. This position also participates in planning, organizing and developing new programs, or changes to existing programs, policies and procedures. It is also involved in program monitoring, evaluation and control. In the larger services, first line supervisory and leadman positions are primarily responsible for immediate work direction of a group of employees and may schedule employees and assist a service chief in his duties.

While a psychiatrist or licensed psychologist have clinical responsibility for each case by approving and signing client treatment plans, the service chief has some clinical responsibility in addition to his primary administrative role. He gives varying degrees of direction and involvement in the clinical aspects of staff supervision, depending upon his professional health background. This position may review cases and treatment plans, suggest changes in treatment implementation, recommend discharge or transfer of clients, and participate in case conferences.

The extent to which the service chief's responsibilities are clinical, and how his duties and those of psychiatrists overlap or integrate, has not been clearly spelled out by the Department. While generally there is a good working relationship between psychiatrists and service chiefs, occasionally issues may not be resolved as readily as possible for lack of specific assignment of responsibility and authority and this could result in ambiguity and conflict that could otherwise be minimized. This is an important policy matter for the Department which should not be left to chance. Program effectiveness and accountability, and medical-legal liability issues require that the Department clearly establish its policies on this subject.

The service chief positions are filled by a variety of mental health classifications. Designation of a person to a service chief position in the mental health system is done at the discretion of the Associate Director of Health for Mental Health, and not necessarily upon any formal job classification, experience, or educational criteria. The

Associate Director of Health for Public Health designates service chiefs in a similar fashion. Currently, three civil service classifications and contract physicians are utilized as service chiefs in the mental health system. These include Staff Psychiatrist, Psychiatric Social Work Supervisor, Supervising Mental Health Nurse, and Recreational Therapist. In Public Health Services, Psychiatric Social Work Supervisors, and until recently a Chief Clinical Psychologist, serve in this capacity. In the Outreach Program, Psychiatric Social Work Supervisors have been designated for these positions.

The first line supervisory and leadman positions are designated by service chiefs in the larger programs such as Inpatient, and in Rehabilitation Services. These positions are filled by mental health classifications including Mental Health Nurse, Psychiatric Social Worker, Mental Health Aide, and Mental Health Rehabilitation Worker. Also, one Administrative Services Assistant I has served in this role in Rehabilitation Services. The Mental Health Aide, Mental Health Rehabilitation Worker, and Administrative Services Assistant may be working out of classification by performing these supervisory duties.

The current classification system was designed for supervision of each particular professional discipline, such as Psychiatric Social Work Supervisor over Psychiatric Social Workers and related sub-professionals. However, the Health Department is organized by program rather than discipline. We believe it must continue to be so organized for continued inter-disciplinary team work and program accountability.

The use of these classifications as service chiefs is awkward for several reasons:

- It emphasizes cross-discipline supervision instead of interdiscipline coordination.

- There are no specific experience or educational criteria for selecting service chiefs.

This results in employees assuming service chief positions with backgrounds which may or may not include sufficient administrative preparation. There is sometimes no civil service recruitment or testing to fill a vacant service chief slot. Competitive examinations are informally bypassed. An existing employee may be designated a service chief who may or may not occupy the same classification as the previous service chief. The salary range is often not equitable with the responsibility of the position, or may cause an inequity in pay with other service chiefs.

There is still a need to select service chiefs from among

the professional health disciplines. As we envision the service chief role, despite its focal responsibility for program administrative matters, there is a continuing and significant responsibility of this position for clinical supervision. It is therefore desirable that service chiefs come from the clinical ranks to be able to competently perform this role as well as be acceptable to clinical subordinates.

The Department has requested the Personnel Management Division to conduct a career ladder study. The intent of the study was to develop a classification system that would provide the opportunity to promote personnel from various classifications into higher level management and clinical positions after meeting as yet unspecified criteria. This study has not been completed, pending the outcome of the operational audit.

From numerous interviews with the mental health professional staff working in the programs, we are convinced service chiefs are performing in a dedicated manner despite adverse conditions of inadequately defined responsibility and authority. The first line supervisory and leadman positions are also performing in a dedicated manner.

RECOMMENDATIONS

17. The Personnel Management Division, in cooperation with the Department of Health, should review the job responsibilities of service chiefs. As a result of this review, a management job classification plan, such as a Service Chief I/II/III series, should be developed for service chiefs as a replacement to the current use of the supervisory job classifications of Psychiatric Social Work Supervisor, and Supervising Mental Health Nurse. This would allow management to develop a structure to properly match program management requirements with appropriate salary and qualification levels for each of the various services.

18. That the minimum qualifications for service chiefs recognize the continued need for demonstrated skills as a mental health therapist due to the need for the acceptance of its clinical supervision from subordinate therapists.

19. The duties specifically assigned to service chiefs should include:

    a) Budget preparation and monitoring in conjunction with the proposed Budget and Fiscal Services Division of the Department.

b) Participating in developing the County Plan and zero base budgeting.

c) Participating in planning, organizing and developing new programs, policies and procedures.

d) Selecting, assigning, and supervising lower professional and sub-professional staff.

e) Controlling use of overtime and extra-help.

f) Taking appropriate action on significant expenditure and revenue deviations from the budget.

g) Actively monitoring and evaluating programs.

h) Reviewing and acting on employee suggestions.

i) Implementing directives from higher management.

j) Preparing status reports for higher management.

k) Ensuring that case information is properly and accurately imputed to the management information system.

l) Assisting in ensuring that treatment plans are carried out as specified by the attending staff psychiatrist who is responsible for quality of care.

m) Detecting and correcting backlogs.

n) Resolving employee grievances.

o) Handling client and public complaints.

p) Employee scheduling.

q) Controlling vehicle usage and permits.

20. Selection of first-line supervisory mental health positions should continue to be accomplished through the formal county recruitment process. Leadman positions should be designated by the service chief (subject to approval by the next higher management level).

21. The Personnel Management Division should review the job responsibilities and classifications of mental health first-line supervisory positions and leadman positions to ensure they are appropriately classified.

22. The service chief, supervisory, or leadman therapist should only get involved in individual case management in a supplementary fashion. They can support the primary therapist with advice to respond spontaneously to an immediate need, due to the lack of availability of the case's psychiatrist or licensed psychologist. However, this should consist of only limited, immediate direction consistent with the diagnosis and treatment strategy approved by a psychiatrist or licensed psychologist.

AUDITOR-CONTROLLER COMMENT

While we concur with the County Administrative Office listed duties assigned to service chiefs, additionally, the knowledge and ability to read and interpret the monthly FMIS reports are necessary in the active monitoring and evaluation of programs. Thereby, the service chiefs' status reports to management will contain accurate, informative financial data as well as programmatic data. The results will be positions whose duties should include coordinating with Financial Services and its staff and support systems as well as clinical duties.

6. ORGANIZATIONAL PLACEMENT OF ENVIRONMENTAL HEALTH

The 1977-78 organization of the Department of Health placed the Deputy Director of Health for Environmental Health in a position directly subordinate to the department head. Section 1250 et. seq. of the California Administrative Code requires public health functions, including Environmental Health, be placed under the direction of the Health Officer. The 1977-78 configuration was possible because the former director was a physician who could be designated the County Health Officer.

The new top level organization adopted by the Board June 12, 1978, called for a lay director of the Department of Health. Consequently, the newly appointed Director of Health does not meet the statutory qualifications for Health Officer. To comply with the organizational requirements of the Health and Safety Code and California Administrative Code, the Deputy Director of Health for Public Health was designated the Health Officer in the interim organization and public health functions including Environmental Health were placed under his direction.

This change added an additional management layer between the Environmental Health System and the Director of Health. In so doing, it necessarily diminished organizational access to the top by a major program component of the Department comprising about 15% of the total Department staff. This development has led us to evaluate this organizational

placement more carefully during the operational audit.

Section 1155.5 of the Health and Safety Code added by statutes of 1974 provides for alternative organizational placement of a County's Environmental Health program under certain conditions. That section and implementing regulations provide that the County may remove Environmental Health from the direct supervision of the Health Officer with the approval of the Director of the State Department of Health Services, provided such a move creates a comprehensive environmental "agency" consisting of at least all the County's environmental health functions.

This provision has been interpreted by the State Department of Health Services as permitting establishment of free-standing Environmental Health departments, within or independent of broader agency structures. Staff of the State Department of Health Services have also advised us that they would approve, if done comprehensively under Section 1155.5, the removal of the Environmental Health System of the Fresno County Department of Health from the direction of the Health Officer and have the program report directly to the department head. Based on these possibilities, we proceeded to examine the issues of where Environmental Health could be managed most effectively within the County structure.

Alternative Of A Separate County Department

Stanislaus, Santa Clara, Ventura, and San Bernardino are counties that have a separate Environmental Health Department which does not report to the Health Officer. The Environmental Health System of the Department of Health could also be made a free-standing department and be placed either within the County's Environmental Management System or the Human Services System. The choice of County systems is itself a significant issue, because it could affect the philosophy and approach of Environmental Health's programs.

Unlike other Health Department systems, a great deal of the responsibility of Environmental Health is to enforce State and local law and State health regulations through inspections and responding to complaints. These rules are designed to maintain a healthful environment for the County's residents and visitors, and give Environmental Health the distinction of being the only Health Department system providing exclusively preventive services. However, these laws can be applied as a strict standard regardless whether conditions warrant, or can be brought to the attention of offending parties in an educational effort where enforcement is only used as a last resort.

This latter approach is prevalent among Environmental Health's programs in this County. Health Department managers partially attribute this to Environmental Health's organizational ties to a service department within the Human Services System. Nevertheless, Environmental Health does have an obligation to enforce lawfully developed standards to abate health hazards and this occasional enforcement posture does make these programs substantially different than other Health Department services. The Health Department has been reluctant to accept the fact that environmental health activities require a strong regulatory component.

This alternative would reduce the number of management layers between the Department Head and Supervising Sanitarians from four to two. Also, Environmental Health requires very little day-to-day business contact with other divisions of the Health Department. Most of their cooperative working relationships are with State agencies, and local city and Fresno County departments of planning, public works, and others found within the Environmental Management System. As a practical matter, in performing Environmental Health responsibilities, there is no substantial coordination or direction needed from the Health Officer (except under declarations of emergency) or other service divisions of the Health Department.

Environmental Health, with its 91 budgeted positions is about the size of other departments in the Environmental Management System, and interrelates with them as peers rather than as outsiders.

As part of the operational audit, we asked Environmental Health employees to log for a one month period their business contacts with other agencies or systems within the Health Department. Out of over 2,600 contacts with over 300 agencies, we found that 34.4% were with other County departments, 20.3% were with other local agencies, and 33.5% of contacts were with other county, regional, State or national agencies and private organizations. Only 10.6% of contracts were with other systems within the Health Department, and they were predominantly administrative support. Some 1.2% of contacts were among programs within Environmental Health. Environmental Health does not interface with the same agencies that other Health Department programs do.

There are several examples of major projects on which Environmental Health has worked in recent years that illustrate its greater orientation toward Environmental Management: Solid Waste Management Plan, Airport Environs Study, General Plan Noise Element, Septage Study,

Air Quality Maintenance Plan, Groundwater Model, and Hazardous Waste regulations.

This alternative would raise the level of visibility of Environmental Health, and relieve it from internal competition for management consideration with other Health Department priorities. Its organizational size might otherwise permit it to be overshadowed for attention by the Health Department's larger and medical-oriented programs and to have decisions about its programs made by top management with insufficient consultation. For example, setting funding priorities between Environmental Health and medical programs requires consideration of policy issues that should be considered outside the confines of the Department of Health. The populations served and problems addressed by the Health Department's other programs are not comparable with Environmental Health, and therefore, do not lend themselves to strictly administrative evaluations and comparisons of cost/benefit to determine their relative importance to the community.

This alternative does have the disadvantage of creating another department head for CAO and Board of Supervisors supervision, and introduces the possibility of increased administrative costs to duplicate support services now provided by the Health Department's three administrative support systems.

Alternative of Reporting to the Director of Health

This option is also permissable under Section 1155.5 of the Health and Safety Code as described above. While broadening the Director of Health's span of control to four major systems from the present three, it does reduce the number of management layers from the Director of Health down to the Supervising Sanitarians (program chiefs) from four to three (see Exhibits I-C and II-C). The importance of reducing management layers is illustrated in finding 4, Organizational Placement of the Air Quality Program.

This alternative places the Director of Health in a better position to be knowledgeable about Environmental Health problems and developments, and to deliver less arbitrary and more informed direction and control over Environmental Health programs. The less remote this important family of programs is from the Director, the less concern there need be that their administration will suffer from inattention or that their priorities will be under or over rated in the Department-wide view.

Health officers, as physicians, do not typically have an Environmental Health orientation. Their expertise is usually in personal health care medicine. Environmental Health requires less medical knowledge and more awareness of environmental health standards, designs, processes, and the physical sciences. Directing Environmental Health through the Health Officer can result in an inadvertent filtering of information, less intense technical monitoring and control, and a conflict of medical public health and environmental health priorities.

Among the considerations leading to the selection of a lay person Director of Health was the Board's interest in utilizing physicians for their technical medical expertise and less in an administrative capacity. This alternative would place fewer administrative demands on the Health Officer, permitting him to concentrate upon public health medical programs and perhaps have time to serve in clinics on a relief basis to maintain close program contact. That contact can be very helpful in monitoring program activity.

A minor shortcoming of this approach is its increase of the span of control of the Director form three to four associates. However, the Director must be knowledgeable anyway about Environmental Health programs, and the increased time if any that would be involved in dealing with a fourth direct subordinate would be reflected in the quality of his knowledge and management of Environmental Health programs. That quality may be at the expense of attention to equally important public health, mental health, and administrative support functions, but is more likely to be balanced through this alternative than through the current structure.

Alternative of Continuing to Report to the Health Officer

Statutes continue to give County health officers environmental health protection responsibilities. The most significant of these are the powers granted in a declared emergency. However, there are also continuing, ongoing requirements for environmental health support to the Health Officer such as epidemiological studies of cases of communicable diseases and the provision of vital statistics. Continued coordination and cooperation can best be insured under the present organizational arrangements.

However, continuing cooperation can also be readily ensured under the preceding alternative by the Director of Health who would be administratively responsible to the Board of Supervisors for carrying out the Health

Officer's functions. Under declared emergencies, the Health Officer would automatically assume command of Environmental Health System resources under any organizational alternative.

Another advantage of this alternative is the already discussed issue of the reduced span of control of the Director of Health. While we view this benefit as minor, it can relieve the Director of some management burden. However, we view the effects of the preceding alternative as more beneficial to the Health Officer than this alternative is to the Director of Health.

This alternative does make the Environmental Health System and its component programs more remote from the Director of Health. Under the present organization, it is the only remaining major County-operated program area in the Department that is unrepresented at the Associate Director level by a well-versed manager. This is disadvantageous for both the Director of Health and the Board of Supervisors because of the sensitivity associated with many Environmental Health programs such as Air Quality and Groundwater Management, and the consequent need for Director of Health involvement. In this way, this alternative also offers less assurance that the health education orientation of Environmental Health can continue to be encouraged, and enforcement activities kept in perspective.

RECOMMENDATIONS

23. That the position of Associate Director of Health for Environmental Health be created.

24. That the Associate Director of Health for Environmental Health report to the Director of Health as depicted in Exhibit II-C, rather than to the Health Officer as under the present interim organizational arrangement (Exhibit I-C).

25. That the Health Department implement these recommendations with the prior approval of the Director of the State Department of Health Services so as to retain Fresno County's eligibility for State Aid for Health Administration.

7. ORGANIZING RESOURCES FOR HEALTH PROMOTION

The Fresno County Health Department has numerous responsibilities as the County's provider of services under the Community Mental Health Services Act and public health statutes. The Department's mental health and public health constellations of programs contain aspects of preventive health, curative, and rehabilitative service. This finding questions how well the Department has balanced its priorities and resources between these prospective and retrospective services, particularly in light of its professed goals. Based on this review we suggest that some adjustments be considered.

Department Goals

In its 1976-77 Annual Report, the Department of Health expressed its goals and they are listed completely in finding 12. Goals affecting this finding include:

-- Provide preventive health services to the residents of the County through education, screening, and referral. Health services should be provided where they are accessible and affordable to all residents. Local centers should offer active programs of continuing interest based on the needs of the community.

-- Promote awareness of the concept of health and well-being and of environmental, social, personal and behavioral hazards to health and to promote social and personal intervention to eliminate or to avoid those hazards.

-- Promote living which is self-reliant, satisfying and secure.

The increasing interest in, and recognition of, the importance of health promotion and preventive health services in the Health Department and throughout the country comes from many sources: the alarming growth of the cost of medical care, the increasing incidence of diseases such as cancer and heart disease which are linked to personal habits and environmental factors, and increased social dysfunction in our population evidenced by crime, suicide, drug addiction, school under-achievement, child abuse, and wife beating.

The Department of Health has responded to these emerging concerns in positive ways. The highly acclaimed Children's Health Play was developed with the help of grant funds. The Department itemized and publicized the seven prerequisites to good health in a mass media campaign in 1977:

1. Learn to relax.
2. Keep your weight in proportion to your height.
3. Get moderate daily exercise.
4. Do not smoke.
5. Eat regular meals, including breakfast.
6. Use alcohol in moderation, if at all.
7. Get adequate sleep each night.

However, there has been little follow-up with these successes, and additional grant funding has not been secured. There has been little reallocation or reorganization of resources in the Department to follow-up on these gains. There has been no long-range planning to identify programming to meet these goals. Existing programs have been expected to incorporate these Department goals into their own service objectives with little or no management guidance or follow-up. The emphasis has continued to be on curative interventions such as crisis or aftercare. Nevertheless, health promotion and preventive services seem to offer the only resource which can raise the general level of health of the population, and conversely reduce the demand for, and public expense for, specialized and technical medical care.

Conceptual Framework

There is considerable discussion among health professionals that most health problems to some degree are a function of peoples' failure to take care of themselves: smoking, poor nutrition, inadequate rest and exercise, inability to relax, being overweight. It follows that the level of health of the population, or peoples' resistance to both major and minor illness, can be improved if people can be convinced they can have an important effect on their own health by assuming responsibility for it. Too many people believe they can take risks with their health for purposes of immediate gratification because the health care system is there to back them up, or do not recognize the connection between their behavior and their health. Health promotion is considered a controversial concept in some quarters, particularly for public agencies, because it is suggesting lifestyle changes in the population to lead people away from dependence upon the health care delivery system to counteract the "diseases of civilization," and to help round out the holistic

approach to health care which depends on an active partnership between the patient and the provider.

Disease prevention services can be described in three tiers. Primary prevention consists of types of interventions designed to alter physical and social environments and/or strengthen peoples' resistence to disease and emotional or mental disorder. It involves lowering the rate of new cases of disease and mental disorder in a population by counteracting harmful circumstances before they have had a chance to produce illness. Primary prevention may be more hazard-specific or disease targeted than health promotion, but they both share mass population intervention approaches. Like health promotion, this includes efforts directed toward the general population, populations at risk, client populations, families of clients and their significant others, and other human service providers. One way to describe the difference between health promotion and primary prevention is that the former teaches people how to be healthier, while the latter teaches them how or helps them to avoid becoming ill. They also both involve the community organization process: assessing needs, mobilizing community resources and providing supportive educational and other services.

Secondary prevention can be characterized as intervention after a physical or mental injury, illness or disorder has struck an individual, usually while still in an acute stage, to avoid the more serious potential outcomes of the illness. The affected individual has, because of the seriousness of his affliction, achieved client status and is treated in the clinical setting. These efforts are directed at reducing the prevalence, rather than the incidence, of disease.

Finally, tertiary prevention is a term used to describe interventions after an illness episode that attempt to help the client regain functions or become less physically or mentally disabled. This is a casualty repair orientation to prevent continuing debilitation.

Most health care system resources, both in the Health Department and throughout the nation, are expended on secondary and tertiary prevention activities. Yet the greatest successes for reducing illness and minimizing human suffering have been achieved by primary prevention. The development and administration of immunizations for polio and many other severe diseases are outstanding examples of this success in the physical health field. In the mental health field, primary prevention has principally taken the form of mental health education services to build social

problem-solving skills and adaptive strengths in people so they are better equipped to resolve their personal problems and avoid becoming psychiatric casualties. Rather than to counter deficits, it seeks to build: strengths of adjustment, adaptation to change, inward security, happiness, ability to perceive alternatives and means-end relations, sensitivity to human problems, awareness of the effects of one's behavior on others, and self-image to achieve sound personal equilibrium, rather than to counter-attack deficits.

A much more experimental approach to primary prevention in mental health is in the modification of social environments. To the extent social systems are not neutral in their effects on peoples' attitudes, moods, behavior, health, sense of well-being, and development, there may be ways to engineer health-promoting environments. Since people respond to different environments in different ways, and social systems generally resist change, further considerable research will be needed to find acceptable ways to manipulate environments to promote mental health.

Distribution of Health Department Resources

The table below illustrates the point that most Health Department resources are devoted to other than their stated health promotion and primary prevention goals. Programs are categorized according to the preponderance of their types of activities, though many programs categorized as other than health promotion and primary prevention may have some elements of these interventions, or a potential for them.

Health Department Program Categories

Health Promotion	Primary Prevention	Secondary Prevention	Tertiary Prevention
Child Health Play	Drug Abuse Education	Older Adult Clinics (PH)	Inpatient
Prerequisites to Health Campaign	Child Health Conferences	Crisis	Older Adult Day Care
	Immunizations	Special Adult Health	Partial Hospitalizatio
	Perinatal Program	Drug Detoxification	Advocare
	Environmental Health	Alcohol Detoxification	Apollo Residence
	Mental Health Consultation & Education	Youth Services Mental Health Out-Patient	Drug Rehabilitation
			Alcohol Rehabilitation
			Youth Day Treatment
			Decentralized Public Health Nursing

Public Health Education	Selma Community Health Clinic	Home Health Agency
Nutrition	Pinedale Community Health Clinic	Crippled Childrens' Services
Rosenberg Grant	Westside Clinics	
	Mental Health Outreach	
	Law Enforcement Counseling	
	Older Adult Service (MH)	

An Assessment of Health Department Commitment to Its Health Promotion and Primary Prevention Goals

Traditional public health and community mental health programs of the Department of Health have always had preventive health components. That is, in addition to curative and screening (early detection) services, the Department has offered services to help prevent individuals from becoming ill. These preventive services have been generally accepted as an effective aspect of meeting local government's public health protection responsibilities. Services tend to be targeted where the greatest needs are, and they emphasize bringing about relatively low-cost changes that can prevent more involved, debilitating illnesses that require much more expensive medical intervention. Consequently, preventive health has been an accepted but low profile partner within the overall health care system which is dominated by institutional curative services.

Within the Department of Health, the amount of time and total resources devoted to health promotion and primary prevention is minor and relatively uncoordinated. This is probably because of the reliance of most of these services upon general County resources for financing, the fragmentation of inexplicit primary prevention responsibilities among many programs, the difficulties of quantifying cost-benefits though they can be significant, and the attention and priority commanded by more directly curative programs that must respond to immediate needs of individuals already ill. So far, tradition (sometimes expressed in minimum statutory requirements), intuitive evaluation and appreciation of preventive health services, and a continuing public demand for some levels of these services, has preserved them within the Health Department, though at minimal levels.

There are numerous examples of the link between mental and physical disorders such as the varying physical and

mental manifestations of a breakdown in an individual's ability to cope with stress. A balanced effort is necessary to achieve maximum results in alleviating each. Coordination is therefore as much an issue as availability of resources to achieve health promotion and primary prevention goals.

A draft plan is circulating within the Department at this time to coordinate and maximize health promotion and primary prevention efforts within all of the Department's clinical systems, as well as in its external relationships with other medical-social welfare agencies. While very few central staff personnel are involved full-time with health promotion and primary prevention, most of the Department's activities in this area are performed in the many clinical programs as incidental activities to their basic missions. We view the development of the draft plan as a positive step toward mobilizing more of the Department's resources to accomplish health promotion and primary prevention as a viable department goal. However, the very nature of the decentralization of most health promotion and primary prevention resources make overall direction and control of the total effort most difficult.

Further efforts are needed to make health promotion realize its promise. Additional financing, probably based on a cost-offset justification, can be pursued at the State and Federal levels. Also, the Department could better pinpoint the responsibility for health promotion and primary prevention planning, coordination, programming, and advocacy. Coordination and effectiveness of disease prevention and health promotion activities could be enhanced if core staff groups already involved in delivering these services were brought together and elevated organizationally.

Service and Support Groups Which May be Consolidated Into a Core Health Promotion and Primary Prevention Service

The Mental Health Consultation and Education Section is currently located in the Program Planning and Development System, as is Public Health Education and Nutrition. These groups are engaged in community organization activities of health promotion and primary prevention already, as well as providing consultation and educational support services to staff within the Health Department and other human service agencies. The mental health and public health services have operated somewhat independently of one another with little coordination despite their organizational and office location proximity. They have had no mandate from management to attempt to coordinate or give

leadership to health promotion and primary prevention activities and goals in the clinical services. Their minimal visibility as a series of individual offices within a support system has also detracted from an overall Department emphasis on these goals and services.

A support group could also be considered for inclusion in the consolidation of health promotion and primary prevention planning, coordination, programming and advocacy. Community Relations, now situated in the Director's Office, has numerous duties other than health promotion and primary prevention. They include providing the Director and program managers with community relations assistance, reviewing release of confidential records, preparation of monthly and annual reports, administering the complaint process, preparation of the staff director and other public information services.

However, the staff has developed an expertise in media relations and programming that can be very useful to health promotion and primary prevention. They have been active in these issues through the Child Health Play and arranging media exposure of related information such as the seven prerequisites to health campaign in 1977. This staff resource could be extremely useful to a consolidated health promotion and primary prevention division, while still providing its other community relations and support services. Its relocation from the Director's Office would also relieve top management of first-line supervisory duties that are difficult to discharge within a top manager's priorities--such as maximizing utilization and coordination of staff resources.

RECOMMENDATIONS

26. That a Chief, Health Promotion Division be established to plan, organize, coordinate and advocate for the Department's efforts toward health promotion and primary prevention goals.

27. That this new division be comprised of the staffs of the current offices of Public Health Education, Public Health Nutrition, Community Relations, and Mental Health Consultation and Education.

28. That this Division report to the Director of Health for improved visibility and Department emphasis upon these goals. It will be necessary to establish an indirect supervisory relationship for the Division with

the Health Officer to satisfy California Administrative Code provisions calling for the Health Educator and Nutritionist to be within the organization headed by the Health Officer (CAC Title 17, Section 1275, 1276). This has been accomplished in the interim organization through written memoranda delegating authority from the Health Officer to the Deputy Director of Health for Program Planning and Development to supervise these offices. The Health Officer has and must nevertheless continue to reserve the right to exercise management direction over these resources to the extent necessary to discharge his statutory responsibilities.

SECTION II. PROGRESS TOWARD GOALS OF THE MERGER

8. HEALTH CARE DELIVERY TEAMS

When the Public and Mental Health Departments were merged in 1974, the purpose was to provide more efficient and appropriate service to the client. As part of this consolidation, the team approach to health care was to be utilized as the catalyst of service integration. It was felt that the merged Health Department, as an entry point into the health care system and as a regional resource of some services, could better coordinate services to address all of the client's health needs. The Health Department was to provide leadership to the health care delivery system to offer comprehensive services in a more effective and efficient way. It was also the intent of the consolidation to make services more available to clients through decentralization of services within the County.

Several goals of the team approach and decentralized services included the following:

-- Services would be more easily coordinated.

-- Delivery of the most appropriate service at the best site by the most appropriate person would be possible.

-- Team delivery could eventually make comprehensive services less costly than traditional systems.

-- More efficient administrative control and supervision would be possible.

-- Greater employee professional satisfaction would ensue from more visible and comprehensive satisfaction of client health care needs.

Advantages of Teams and Decentralization

Health care teams are necessary to some extent because of the complexity of medical and psychiatric health services and the number of types of health specialists currently utilized. For instance, there is the need for different skill levels. Optimal health care requires skills that range from the most elementary, such as turning and bathing

a baby, to the most complex, such as cardiac diagnosis. Because of increasing health care costs, it is imperative that skilled professionals not be underutilized by having them perform functions that can be done as well and less expensively by lower skilled personnel.

When necessary, the ability to exchange information between mental health and physical health disciplines can increase the opportunity of discovering underlying health problems and perhaps lead to more effective treatment. The health needs of many patients require this team collaboration. Integrated health care delivery would include addressing the client's mental, physical and environmental health needs.

In Fresno County, health care must be delivered in a variety of sites if it is to be accessible and if the patient is to receive timely diagnosis, treatment, and support services. Although the primary consideration about where care will be given should depend upon what is best for the patient, it must take into account what is feasible and realistic for the system. Some services, because they require special equipment and personnel, can be provided only in regional ambulatory care settings of hospital and special treatment facilities. Some, like assessment of the home environment or provision of home nursing services and "outreach," can take place only in the home or community setting.

Limitations of the Team Concept and Decentralization

There are limited benefits in many instances of an integrated health care system attempting to treat the patient and the family. This is particularly the case if the client will only accept limited curative service or benefit only from appropriate limited treatment by a specific discipline or program.

Progress Toward Health Care Team Development

We have reviewed the Department's progress toward the goals mentioned previously, in particular the utilization of health care teams.

Central Mental Health Programs

Multi-disciplinary health care delivery focus is the central health services is not well developed. Few mental health programs include the integration of physical and environmental health components. There does not appear to be much interest in dealing with more than a client's immediate emotional and mental ability.

This lack of interest may be due in part to the present separate locations of mental and physical health programs.

Central Public Health Programs

Like in the mental health services, the multi-disciplinary health care focus in the centrally located public health programs is not well developed. The current central public health categorical clinic approach does not fully take into consideration mental health, environmental health, or comprehensive physical health needs of clients. The delivery of services is done through categorical specialized clinics such as the Well Child, Older Adult, Special, Chest, and Family Planning. To a considerable extent, the approach is influenced by categorical funding for public health services. However, greater attention may be paid within the specialized clinics to more comprehensive assessment of client needs and referral for additional services.

Decentralized Health Services

It was the Department's interest in health team integration and in decentralization of services that led to the development of the Decentralized System as the leading edge of integrated health service delivery through rural health centers. The scale of operations were to be more manageable, and the rural settings were expected to be a more receptive atmosphere for innovative methods of service delivery because of the undersupply of both generalized and specialized medical services. As a result, progress to date toward development of multi-disciplinary health care teams has been primarily in the decentralized health centers.

At the decentralized health centers, patients may see several classifications of employees from staff nurses to family nurse practitioners. They may also see contract physicians for physical ailments. Patients normally are not routinely seen by mental health personnel unless they request assistance or they exhibit an immediate need for mental health or substance abuse services. Through the Decentralized Health System, an atmosphere of cooperation between the Mental Health Outreach, Decentralized Public Health Nursing, and clinical medical staffs has been developed at these decentralized sites.

This is in part because the system was initially staffed with motivated volunteers from throughout the Department's other programs who had a sincere desire to see the decentralized sites succeed in these goals. Team activities

of Public Health Nurse and Mental Health Outreach staff, using health centers as a central medical resource, include case referrals among the disciplines, joint teaching, home visits, and case conferencing. The decentralized staff at each site meet weekly to discuss joint interests and share knowledge of one another's services which is necessary to trigger formation of the team network on specific cases. Formal protocols to initiate team interaction have not been necessary because Decentralized System staff clusters are small and relatively cohesive. In particular, at Pinedale, housing all staff in one facility has facilitated more frequent professional interaction. Health records are now more coordinated and information is more accessible to staff who need it. The sites are also administered through joint on-site management. The administrative focus is centered on more than specific programs or discipline. In short, there is considerable multi-disciplinary training, consultation, intervention, planning, and service delivery.

These processes have helped the various health personnel involved to become more aware of the resources that various primary care programs offer and how they can work together or separately to benefit clients. The result is considerable coordinated patient care.

Future of Health Care Teams in the Department

While tremendous strides have and continue to be made toward multi-disciplinary team integration in the Decentralized System, the Department faces a more difficult challenge to extend its commitment to an integrated health delivery approach in its centralized public and mental health programs. With the coming relocation of most public health services on the Mall, the Department has an improved opportunity to extend the concept to its central public health services. Eventually, mental health services will also be included. The mechanisms will nevertheless be difficult to develop given constraints of categorical funding, finite resources, the resistence of entrenched specialized programs, and established constituencies.

RECOMMENDATIONS

29. The Department should assess the practicality of health care teams for centralized services and determine at what level integration of services should occur such as the consultation and education level, planning level, or the consumer level.

30. The Department should research the literature to locate where integrations have been tried

elsewhere. These other experiments should be analyzed to isolate those elements of integration design with the best potential for practical and effective service delivery.

31. Various team models should be developed and tested by the Department to find the most cost-effective patterns. Where useful, protocols could be developed showing when and why there should be consultation or collaboration between various health programs and disciplines. A starting point for developing these criteria might be identifying what presenting conditions of a client have a high probability of causing, or being the result of, other ailments. Model designs should specify team specialty composition, roles of members, individual and team goals, team member coordination and collaboration mechanisms, and patient flow schemes to meet holistic health requirements.

32. That the Department continue refining the multi-disciplinary health care delivery team model organization in the decentralized health programs. This is where the most progress and greatest philosophical commitments have already been made. The unified management of the health centers, decentralized nursing, mental health, and drug abuse outreach staff under the Health Officer should facilitate cooperation and innovation.

33. The Department of Health should renew its professional commitment to the goals of the merger. While many employees have retained that initial commitment and inspiration, the Department as a whole needs to mobilize its energy and motivation to reach these very difficult but significant goals. If holistic health services are to be expanded into the Department's centralized programs, those affected staff must develop the will and get into the habit of working in multi-disciplinary teams.

9. ANTICIPATED IMPACT OF SPACE CONSOLIDATION

Currently, the Department's community-wide programs and central staff support groups are located at the Kings Canyon complex and several other sites (many leased) throughout

the City of Fresno (Exhibit VI). The pending move to the Fulton Mall is expected to improve the Department's ability to deliver health services by consolidating the location of most department programs, staff support, and management personnel currently scattered in a number of locations. Approximately three-fourths of the planned space needs of the Health Department (100,000 sq. ft.) will be located in the Brix-Mercer buildings.

Consolidating central programs would allow for improved client access to the Department's health delivery services, better communications between staff, better opportunity for program integration, and better linkage of clients between services. Properly designed facilities should generally provide for more efficient and effective operation of the Department's programs.

The Center for Environmental Change, Inc., has prepared a detailed report outlining with schematics the interior layout of the space in the remodeled buildings. This consultant surveyed the needs of the Department, conducted on-site observations of existing Department work spaces, and interviewed approximately 60 individual department personnel at all levels in the organization. The Center further worked with 35 employee work groups, which ranged in size from 6 - 20 members and included supervisory and second level management. The work groups met in two rounds of workshops in the Fall of 1977. Space requirements, the need for various programs to be adjacent to other programs, and desired special features and characteristics of various programs were considered. Schematic designs were then developed showing space layouts for the various work activities of the Department. The former Director of the Department also took a special interest in determining the design of the space layout.

The Environmental Impact Report prepared for the old St. Agnes Hospital site proposal included a thorough review of the parking needs of the Department. The peak parking demand anticipated was 40 spaces for clients and 391 for employees. Of the 391 employee spaces, 200 would be for priority parking for those using their cars on county business, physicians, p.m. shift employees, and executive staff.

When the Mall location was selected, it appeared there was sufficient parking available on nearby City-owned property. The City has indicated their first priority is providing short-term parking for the Mall commercial area. Preliminary discussions with City staff indicated 524 spaces on City lots are available for long-term rental. However, if a shortage of short-term spaces develops, the County could lose parking spaces it might be renting from the City.

Currently, the County is in the process of acquiring the Bank of America property near the Brix and Mercer buildings which would provide 70 to 90 parking spaces. The Department would still need 150 to 180 priority and client spaces and 191 non-priority employee spaces. The Administrative Office is currently working with the Health Department on a long-range parking plan and will be reporting back to the Board of Supervisors in the next few months. The Health Department is assisting in this effort by updating the parking demand estimates used in the Environmental Impact Report prepared for the old St. Agnes Hospital site proposal. There is $1.2 million in the current budget for long-term parking.

The great amount of involvement by department staff in planning of work areas should greatly aid in ensuring a smooth transition to the new facilities by staff and clients. It should greatly assist in the success of the layout for promoting efficiency and inter-program and staff coordination.

RECOMMENDATIONS

None.

FRESNO COUNTY DEPARTMENT OF HEALTH

1978-1979 LEASES, ALLOCATIONS & COSTS

	Program	Location	Square Footage	Cost Per Year	Utilities Included
1.	Air Quality Maintenance	Suite 401, Townehouse	500	$ 3,024	Yes
2.	Central Nursing Team	311 North Fulton	810	3,720	Yes
3.	East Nursing Team	Hale Medical Center	996	6,574	No
4.	Home Health Agency	1350 "O" Street	2,200	12,000	Yes
5.	North Nursing Team	36 E. Minarets	1,000	6,000	Yes
6.	East Nursing Team	Kerman Community Center	700	336	Yes
7.	MDO Program	1350 "O" Street	1,280	7,200	Yes
8.	CHC/CHDP	Lady of Guadalupe Parish	N/A	480	Yes
9.	CHC/CHDP	Baptist Church, Coalinga	N/A	180	Yes
10.	CHC/CHDP	Kerman Community Center	2,200	360	Yes
11.	CHC/CHDP	Salvation Army Building	N/A	180	Yes
12.	CHC/CHDP	Trinity Lutheran Church	N/A	240	Yes
13.	West Outreach	Kerman Community Center	2,200	816	Yes
14.	West Outreach	Sunset School	1,774	1,200	Yes
15.	West Outreach	Hale Medical Center	820	5,702	No
16.	East Outreach	311 North Fulton	1,350	5,040	Yes
17.	East Outreach	St. Andrews Church	N/A	1,500	Yes
18.	Crisis	Mental Health Modulux	8,800	33,940	No
19.	Client Information	Mental Health Modulux	1,021	3,938	No
20.	Billing & Collections	Mental Health Modulux	1,864	7,189	No
21.	CCS	Mental Health Modulux	1,800	6,942	No
22.	Inservice Training (M.H.)	Mental Health Modulux	484	1,866	No
23.	Inservice Training (P.H.)	Mental Health Modulux	484	1,866	No
24.	Medical Education	Mental Health Modulux	735	2,836	No
25.	Eligibility (M.H.)	Mental Health Modulux	570	2,198	No
26.	Youth Services Outpatient	Mental Health Modulux	8,700	33,554	No
27.	County Counsel	Mental Health Modulux	274	1,057	No
28.	Health Education	Mental Health Modulux	384	1,481	No
29.	Older Adults (M.H.)	4777 E. Belmont	2,700	900	Yes
30.	Older Adults (M.H.)	4826 E. Fillmore	2,700	8,680	No
31.	Perinatal	Suite 400, Townehouse	1,740	8,352-Rent 1,940-Penalty	Yes

	Program	Location	Square Footage	Cost Per Year	Utilities Included
32.	Pre-Vocational Center	826 N. Fulton	4,826	$13,440	No
33.	Rosenburg Grant	34 E. Minarets	1,000	6,000	Yes
34.	Substance Abuse Admin.	Suite 425, Townehouse	600	3,600	Yes
35.	Program Evaluation	Suite 500, Townehouse	1,468	7,047	Yes
36.	Data Processing	Suite 507, Townehouse	1,540	7,392	Yes
37.	Environmental Health	Suite 600, Townehouse	3,327	15,970	Yes
38.	Accounting	Suite 615, Townehouse	1,090	5,232	Yes
39.	Consultation & Education	Suite 620, Townehouse	440	2,112	Yes
40.	Health Education	Suite 620, Townehouse	550	2,640	Yes
41.	Nutrition	Suite 620, Townehouse	345	1,656	Yes
42.	Inservice Training	Suite 620, Townehouse	615	2,952	Yes
43.	Personnel	Suite 720, Townehouse	621	2,952	Yes
44.	Newsletter	Suite 720, Townehouse	100	480	Yes
45.	Vital Statistics	Suite 720, Townehouse	830	3,984	Yes
46.	Central Administration	Suite 800, Townehouse	1,332	6,394	Yes
47.	Community Relations	Suite 800, Townehouse	734	3,523	Yes
48.	Advisory Boards	Suite 800, Townehouse	454	2,179	Yes
49.	Program Planning	Suite 800, Townehouse	1,019	4,891	Yes
50.	Financial Services	Suite 800, Townehouse	740	3,552	Yes
51.	Administrative Services	Suite 800, Townehouse	657	3,154	Yes
52.	Youth Health Services	Suite 800, Townehouse	786	3,773	Yes
53.	Adult Health Services	Suite 800, Townehouse	960	4,608	Yes
54.	Decentralized Health Svcs.	Suite 800, Townehouse	899	4,315	Yes
55.	Environmental Health Svcs.	Suite 800, Townehouse	737	3,538	Yes
56.	Substance Abuse	Suite 800, Townehouse	945	4,536	Yes
57.	General Services	Storage, Townehouse	500	1,116	Yes
58.	General Services	Parking, Townehouse	N/A	4,860	N/A
59.	Family Planning	Winton Building	3,200	15,360	No
60.	Special Health Clinics	Winton Building	1,800	8,640	No
61.	Work Opportunity Center	461 & 457 W. Minarets	2,952	3,240	No
62.	Firebaugh Comm. Health Ctr.	New Building	---	26,000	No
63.	Pinedale Comm. Health Ctr.	30 E. Minarets	3,160	23,010	Yes
64.	Selma Comm. Health Center	2057 High Street	2,115	13,980	Yes
65.	Selma Comm. Health Center	New Building	---	53,520	No

PP&D
8/1/78

SECTION III. HEALTH ADVISORY BOARDS

10. COVERAGE OF PROGRAM AREAS BY ADVISORY BODIES

The Health Department works closely with six Board of Supervisor appointed, and one independent, advisory bodies which were established to provide a vehicle for citizen advice, review, evaluation, and report on the particular programs they oversee.

The advisory boards and/or committees with which the Department of Health works are:

1. Mental Health Advisory Board (MHAB)
2. Advisory Committee on Drug Abuse
3. Alcoholism Advisory Board
4. Child Health and Disability Prevention (CHDP) Advisory Board
5. Selma Community Health Center Advisory Committee
6. Pinedale Community Health Center Advisory Committee
7. Coordinating Council for the Developmentally Disabled.

Their powers, duties, and membership terms are discussed separately below.

Mental Health Advisory Board

The powers and duties of the MHAB are spelled out in Section 5606 of the Welfare and Institutions Code and include:

a) Review and evaluation of the community's mental health needs, services, facilities, and special problems.

b) Review the County Short-Doyle Plan.

c) Advise the Board of Supervisors and the local mental health director as to any aspect of the local mental health program.

d) Submit an annual report to the Board of Supervisors.

e) Make recommendations regarding appointment of a local director of mental health services.

f) Review and approve procedures used to ensure citizen and professional involvement at all stages of the planning process.

Members are appointed by the Board of Supervisors based on statutory guidelines for membership profiles which include mental health professionals, providers, clients and citizens in the community. Members serve three-year staggered terms.

Advisory Committee on Drug Abuse

The Advisory Committee on Drug Abuse is established under Section 5606.5 of the Welfare and Institutions Code. Its powers and duties are as follows:

1) Reviews and evaluates the community's drug program needs, services, facilities, and special programs.

2) Review the drug program portion of the County Short-Doyle Plan. This review, at the option of the County under legislative amendments of 1975, may be in lieu of the mandated review by the local MHAB.

3) Act in advisory capacity only, reporting findings and recommendations to the County drug program coordinator designated pursuant to Section 11962 Health and Safety Code.

4) Under legislative amendments of 1977, the Board of Supervisors could designate the committee to be the advisory body to review and approve procedures to ensure citizen and professional involvement at all stages of the planning process leading to adoption of the drug program portion of the County Short-Doyle Plan pursuant to Welfare and Institutions Section 5651(i). This would be in lieu of MHAB review and approval.

We have been unable to locate any Board of Supervisors resolutions which indicate the Board has elected to designate the Advisory Committee on Drug Abuse in place of the MHAB to provide the mandated review of the drug portion of Short-Doyle Plan, or the review of procedures to ensure citizen and professional involvement at all stages of the

planning process. However, the committee has been operating in this capacity since 1976.

Members are appointed by the Board of Supervisors for three-year staggered terms.

Alcoholism Advisory Board

Section 11795-11802 of the Health and Safety Code establishes the Alcoholism Advisory Board with powers and duties to:

a) Review and evaluate the County alcohol program budget, the community's alcohol prevention, treatment, rehabilitation needs, services, facilities, and special problems, and may make on-site visits to such facilities and interview persons who have received care from such facilities.

b) Advise the County alcoholism administrator on policies, goals, and operations of the County alcoholism program and other matters related to alcoholism.

c) Encourage public understanding of alcoholism and support throughout the County for development and implementation of effective alcoholism programs.

Members are appointed by the Board of Supervisors for three-year terms.

Child Health and Disability Prevention Advisory Board

Section 321.7 of the Health and Safety Code establishes the CHDP Advisory Board. Its responsibilities include:

1) Review of the community's child health needs and the adequacy of health care providers and facilities to meet those needs.

2) Review of the child health and disability prevention plan.

3) Advising and reporting directly to the Board of Supervisors concerning a program for child health and disability prevention.

4) Such other duties relating to child health which may be delegated to it by the Board of Supervisors. We have been unable to locate any Board resolutions which have assigned any additional responsibilities to this committee.

Members are appointed by the Board of Supervisors for three-year terms.

Selma and Pinedale Community Health Centers Advisory Committees

The Selma and Pinedale Community Health Centers Advisory Committees were informally established by the Department to ensure community involvement concerning the needs, services, and facilities of the community health centers in Selma and Pinedale. These committees, unlike the previously mentioned boards and committees, are not required by State law. By Board resolution of November 28, 1978, the County Administrative Office has been directed to recommend terms, number of members, and review by-laws in preparation for establishing these two committees as formal advisory bodies to the Board of Supervisors.

Coordinating Council for the Developmentally Disabled

The Coordinating Council for the Developmentally Disabled has informally advised the Department of Health during the past three years on matters affecting the developmentally disabled. The Council was originally constituted as an advisory group to the Sequoia Area Board VIII, which is a seven-county board established by State law to deal with developmentally disabled issues and concerns on a regional basis. On October 9, 1978, the Board of Supervisors officially accepted the Coordinating Council for the Developmentally Disabled as a County advisory board. Its objectives as stated in their by-laws are:

1) To promote the general welfare of the developmentally handicapped in Fresno County.

2) To solicit and receive funds for the accomplishment of the above purposes.

3) The coordination and implementation of the functions of this organization will be accomplished in conjunction with the Board of Supervisors of Fresno County, Comprehensive Health Planning in Central California, the Central California Regional Center for the Retarded in Fresno County and such other agencies as necessary to accomplish its purposes.

4) To review all grants which provide services to the developmentally disabled in Fresno County; e.g., revenue sharing grants, State Department of Health grants, Sequoia VIII Area Board grants, etc.

5) To conduct an accurate unmet needs assessment of the developmentally disabled in Fresno County.

6) To review and evaluate pending legislation concerning the developmentally disabled and provide recommendations.

Prospects for a Department of Health Advisory Board

During the course of our study, we have monitored the meetings of several of these bodies and have found them to be providing productive input to the Department. However, not all programs of the Health Department are overseen because of the categorical nature of these bodies.

One possible alternative is to establish one advisory body with the responsibility to advise on all Department of Health operations. This body would be established under the authority of the Board of Supervisors, but could not as a practical matter replace any of the bodies listed above except the Pinedale and Selma Committees and the CHDP Advisory Board (Health and Safety Code 321.7). This conclusion is based upon the statutory foundations for these committees, and the differing numbers and qualifications for membership, terms, and responsibilities provided by State law (see Exhibit VII). The Coordinating Council for the Developmentally Disabled is an independent, incorporated body which is not subject to Board of Supervisors appointment.

The Department-wide committee could be established to either overlap with existing committees, or address all other programs not directly covered by existing committees. The latter approach appears more practical since duplication from overlap could result in conflicts in direction and costly demands on the time of affected program managers. Also, the categorical nature of advisory bodies helps in locating citizens who are motivated to serve by program interest. A single committee providing oversight to all of the Department's programs would be hard pressed to acquire the program and issue expertise in all programs that the County now enjoys from its specialized advisory bodies.

Public Health Advisory Board

Gaps in Health Department program oversight by advisory bodies appears to only exist in the public health area.

Public health has three advisory bodies which are narrow in scope. The CHDP Advisory Board oversees one child health program only. Selma and Pinedale Community Health Center Advisory Committees concentrate on their geographic community interests. All other public health and all environmental health programs receive no citizen advisory body input.

If an existing advisory body were to be utilized to cover the broad range of public health programs, the CHDP Advisory Board would be the logical choice because of its Countywide scope. However, this alternative has similar limitations as a Department-wide advisory body such as specialized membership qualifications (three parents, two of which are Medi-Cal eligible; three physicians; one education representative; six health professionals such as dentists, child development specialists, school nurses, etc.), member motivation and program competence. For these reasons, an expanded scope CHDP Advisory Committee, or a public health committee with concurrent membership to the CHDP Advisory Committee, may not be practical.

Two More Advisory Boards of Broad Jurisdiction

The breadth of programs remaining to be covered is awesome compared to the programs and patient populations covered by existing committees. Even if the decentralized system continues to be covered by local community committees, there are numerous programs in the public health and environmental health organizations left to cover. There are 23 environmental and consumer protection programs including air quality, plus Crippled Children's Services, public health nursing, specialized adult clinics and programs, other child health programs, immunizations, and a proposed health promotion organizational unit.

Further proliferation of advisory bodies to the Department of Health may be counterproductive. Each existing committee has required the time and involvement of top managers of the Department. The former Director estimated his personal involvement at as much as 20 hours per week. However, lower level managers would experience fewer demands from categorical committees since the number affecting them diminishes down the ladder. For this reason, the benefits of counsel and community support to be obtained from rounding out Health advisory body coverage probably outweigh the administrative liabilities. Two more advisory bodies, one for environmental health and another for uncovered public health programs, might obtain sufficient program specialization and interest, yet impose time demands primarily on managers who are still relatively free of advisory committee liaison commitments.

RECOMMENDATIONS

34. That the Board of Supervisors give consideration to establishing a Public Health Advisory Committee, charged with providing citizen input, advice, and assistance to all public health programs not already covered by categorical and regional bodies.

35. That the Board of Supervisors give consideration to establishing an Environmental Health Advisory Committee to provide similar functions as shown in the preceding recommendation for public health programs.

36. If your Board tentatively decides to proceed, that the County Administrative Office and Director of Health be instructed to prepare proposed duties and membership characteristics for the new advisory bodies to ensure balanced representation and clarity of purpose.

37. That the Department of Health submit to the Board a proposed resolution formally clarifying the role of the Advisory Committee on Drug Abuse.

EXHIBIT VII

MEMBERSHIP CHARACTERISTICS OF BOARD APPOINTED HEALTH ADVISORY BODIES

	CHDP	DRUG ABUSE	ALCOHOL	MHAB
Number of Members:	13	15	15	17
Terms:	3 years	3 years	3 years	3 years
Qualifications:	3 - Parents 3 - Physicians 1 - Education Representative 6 - Other Child Health Professionals (Dentists, Child Development Specialists, School Nurses)	No breakdown specified. Membership to consist of rerpesentatives of law enforcement agencies, private drug programs, education and the general public.	Representatives from various economic, social, and occupational groups with professional, personal, or research interest in alcoholism. At least three of the members are to have been recipients of treatment or rehabilitation services from their alcoholism programs.	51% or more of the 17 (9) must represent the public interest in mental health. Half of the 51% (5) members are to be persons, parents or spouses of persons, or adult children of persons who have received mental health services. Other public interest representatives (4) come from the following professions: - Criminal justice - Fiscal management - Law - Education Also - 2 Physicians (one of the two is a Psychiatrist) Remaining members to be selected from the following: - Psychology - Social Work - Nursing - Marriage and family counseling - Psychiatric technology - Hospital/community mental health facility administration No member of the advisory board or his or her spouse shall be a full-time county employee of the county mental health service, an employee of the State Department of Mental Halth, or an employee of a Short-Doyle contract facility. Changed per Chapter 852 of statues of 1978.

11. DEPARTMENT ASSISTANCE TO ADVISORY BOARDS

There are similar recurring duties among the health advisory boards which are discussed individually in finding 10. The purpose of advisory boards and committees is to provide information and advice to the Board of Supervisors and the Health Department from a perspective outside the County organization. They assess needs; determine how well plans and services are responsive to those needs; suggest changes where desirable in policies, goals, and operations to improve responsiveness; and ensure citizen input in the planning process.

We believe the Board of Supervisors implicitly has additional expectations of advisory bodies concerning the manner in which they perform their duties. These include the exercise of independent judgment; acting on sufficient, sound and well-rounded information; and attention to matters pertinent to encouraging the appropriate delivery of effective health services in the programs they oversee. The posture with which the Department's management assists, communicates and interrelates with advisory bodies can either be supportive of their independence and competence, or can compromise it.

During the course of the audit, our staff attended numerous meetings of several of the advisory bodies, including full membership meetings and executive committee meetings. During these meetings, we observed Department managers and staff perform the following types of functions in their relationship with the advisory boards:

1. Provision of secretarial support (minutes, meeting scheduling, preparation and distribution of committee initiated correspondence and agendas, business travel arrangements and claims for reimbursement, and distribution of incoming correspondence to committee members).

2. Briefings of fact on program points of information such as important developments in the program(s) with which the advisory boards are concerned.

3. At the request of advisory bodies, explain Department of Health or County proposals, policies and procedures.

4. Self-initiated participation in advisory board discussions and deliberations to advise, question, and provide information which could direct or guide the interests or inquiries of the advisory boards, on occasion participating in discussions as if they were a member.

5. On the initiative of the program manager, offering for advisory body endorsement some specific proposals of a program manager or higher management to influence the decision of the Director of Health or the Board of Supervisors. Sometimes these matters have had potentially direct effect on the program interests of advisory boards, and sometimes the possibility of an effect has been indirect or remote.

We recognize the importance of the first three types of support to the advisory boards if they are to function properly and provide useful advice. However, we have some reservations about some aspects of the last two forms of participation in advisory committee business regardless of the innocence and well-meaning of the employee's intentions.

Health Department Employee Participation in Committee Business

In order to properly discharge their responsibilities, advisory boards must have access to and be accessible to input from providers, community interest groups and service agencies, patients and their relations, non-management and non-confidential employees of the Department of Health, and other persons interested in the planning and delivery of health services. Management and confidential employees, on the other hand, must approach advisory bodies with a professional posture that cannot be construed as attempting to manipulate the interests and direction of advisory body inquiry or position statements. They are too closely associated with official County policy or the process of formation of Department or County management policy to be regarded as independent or unbiased advisors and participants.

The Department cannot afford the appearance of inappropriate participation by its management and confidential employees in advisory committee deliberations. This approach could not only jeopardize the credibility of the Department as viewed by the advisory boards, but also jeopardize the credibility of advisory boards as viewed by the public and the Board of Supervisors. The Board of Supervisors must be able to rely on the integrity and independence of advisory board judgment and advice for them to be effective. Any appearance they may be the captive of the Department's official viewpoint would also dilute in the eyes of the Board of Supervisors and the public the significance of their legitimate support of worthy department proposals.

Although we do not have any specific recommendations covering this area, we have shared our concerns with the Director of Health and the various advisory boards. We are in agreement that the relationship between the Health Department and its advisory boards should be maintained through effective communication, mutual respect and cooperation.

SECTION IV - MANAGEMENT PLANNING, DIRECTION, AND CONTROL PRACTICES

12. PROGRAM PLANNING

The Department has had extensive planning mechanisms in one form or another for a number of years. The 1968 amendments to the Short-Doyle Act required counties to annually prepare and submit to the State Director of Mental Health a local plan for the delivery of local mental health services. This plan continues to provide the basis for coordinating community and Statewide mental health programs and State participation in locally operated program costs.

The required Short-Doyle plan elements include: a) description of target groups served, b) descriptions of the direct service programs provided, c) descriptions of indirect and supportive services, d) statements of progress, and e) estimated utilization of State hospital services by county programs for the succeeding fiscal year. Optional plan items include establishment of treatment programs for mentally disordered jail inmates and juveniles in detention facilities.

These are major categorical elements. Within these categories, however, there may be new planning elements imposed by the State which can result in a very complex plan document. For example, the State requires that the County's 1979-80 Short-Doyle plan address the mental health resources, professional and other personnel within the County which may be used in developing programs related to minority mental health needs. There are other additional plan changes which place greater emphasis on proportionate ethnic representation on advisory boards. These changes can in turn result in additional data requirements, certifications, and preparation of other documents.

The plan is to distinguish between approved and existing programs, new and/or expanded programs for the next fiscal year that are compatible with the Governor's budget, new or expanded programs which are not compatible with the Governor's budget (in order of priority), and services purchased from the State including usage of State hospitals.

Other programs which require the Health Department preparation and submission of a plan are the Alcoholism, Drug Abuse, the Child Health and Disability Program and Air Quality

programs. These plans are less complex and voluminous than the Short-Doyle Mental Health Plan.

Grant applications also represent an activity in which planning takes place to describe the services and objectives the Health Department proposes to offer with the grant award. This is necessary to convince the granting agency the County's objectives will coincide with the purposes for which the grant is offered. For example, the Firebaugh Community Health Center grant requirements include the preparation and annual submission of a plan and budget to the Department of Health, Education and Welfare.

The State Department of Health required counties in 1970 to use a management by objectives (MBO) approach to county mental health programs. In 1974, the County Department of Health extended the MBO process to include all of its other programs. This was done to help unify the budget process in the newly-merged department, which prior to 1974, were the separate Departments of Public and Mental Health. In addition, the MBO process was felt by the Department to be a good management tool for line managers because it allowed for more goal-oriented work direction.

Plan Monitoring

A number of activities take place which ensure program goals are being met. Program managers report progress attained in meeting objectives established by the planning effort on a quarterly basis. Managers make use of the Mental Health - Management Information System (MH-MIS) output reports, automated independent data module reports, or manually prepared reports to prepare the MBO progress reports.

Part of the Program Information and Evaluation Services Section (PIES) functions include continual review of MH-MIS data which serves as an indirect check to ensure that program objectives are being met. In addition, the formalized program evaluation reports also provide a form of assessing goal attainment. PIES services are discussed in greater detail in finding 13, Program Review and Evaluation.

Goals Should Be Re-evaluated and Updated Periodically

Prior to 1977, the goals of the Department tended to be the sum of each of the various system/program goals. In 1977, however, the Department developed through employee participation a formalized set of 16 goals (11 external/5 internal) which reflected the combined efforts of the Department's systems. These goals were accepted unanimously without modification by departmental staff. They were published in the Department's 1977 Annual Report. The Board of Supervisors adopted these same goals in the Spring of 1977. These are shown below in priority order.

External Goals

1. Provide preventative health services to the residents of the County through education, screening, and referral. Health services should be provided where they are accessible and affordable to all residents. Local centers should offer active programs of continuing interest based on the needs of the community.

2. Provide quality health care delivery system through health maintenance and prevention of diseases to entire County.

3. Provide the best and most efficient health services to the greatest amount of people with the least amount of wasted material and personnel potential.

4. Provide adequate health care to the rural residents of the County.

5. Promote awareness of the concept of health and well being and of environmental, social, personal and behavioral hazards to health and to promote social and personal intervention to eliminate or to avoid those hazards.

6. Collaborate with health providers in Fresno County and bordering areas that provide consumer health services in Fresno County and develop a comprehensive non-duplicative health delivery system.

7. Educate the community to all the types of services that are available to them, as well as utilization of services.

8. Promote living which is self-reliant, satisfying and secure.

9. Utilize community input in further development of Department goals that would reflect current community needs.

10. Create better liaison or communication between departments; i.e., Welfare, Environmental, Mental Health, Juvenile, Probation, Parole, Valley Medical Center, Administration.

11. Secure a facility that will house more than one segment of the Health Department so the public will not have to run all over town for services. Unification of the Department.

Internal Goals

1. Establish more effective trust, coordination and communication between staff administration, emphasizing line worker input and instituting a "workable" matrix.

2. Coordination, cooperation and communication between and within services of the Department.

3. Establish a priority for setting goals which will promote employee morale; e.g., career ladder, reward for longevity, initiative, and leadership.

4. Provide more job satisfaction for employees by providing adequate staff, equipment and space to accomplish service delivery.

5. Reduce bureaucracy.

There are factors which may prompt reconsideration of these goals or their priority order. Examples are: economic factors (Proposition 13), future legislative changes in the Short-Doyle allocation formula, other legislative changes at the State and Federal levels, possible changes in Board of Supervisors policy, and/or changes in amount and type of privately owned health care organizations, facilities, and services. Department plans should be re-evaluated periodically to ensure consistency with current conditions.

MBO program statements should also be consistent with the overall Department goals. MBO goals for the individual programs are intended to be recompiled annually and are subject to potentially substantial changes to meet new challenges and opportunities. These goals and changes to goals are reflected in theannual plans prepared by the line managers.

Lead responsibilities for plan development appear to vary among the systems in the Department. For example, the Program Planning and Development System has the lead responsibility for coordinating and developing the County's Short-Doyle Plan. This plan is a compilation of the ZBB/MBO plans written by line managers. The information is presented in a different format prescribed by the State Department of Mental Health. Program Planning and Development handles the coordination and preparation of the overall package. They schedule the process, ensure that training about the ZBB/MBO process is given to line managers, and assist those managers in putting narrative statements into the ZBB/MBO format.

The preliminary and final Alcoholism and CHDP plans, however, are prepared by their respective program managers. The Drug Abuse portion of the Short-Doyle Plan for 1978-79 was prepared by Program Planning and Development in consultation

with Drug Abuse Program staff. Before 1976, the Drug Abuse and Alcohol Plans were prepared under the same Short-Doyle budget/plan process as Mental Health Services. When the State established the Alcohol Program as separate (1976), the Alcohol Program Administrator assumed complete responsibilities for plan development and preparation.

We concur with the Department that plan development should be a primary responsibility of the system responsible for providing the service. Placing development responsibility with the direct service systems, and review with top level management with assistance provided by the administrative services system, helps ensure more meaningful planning, while promoting greater consistency between plans and actual program direction. The planning and writing of ZBB/MBO plan documents by service chiefs and program managers should help make them more aware of the program outcomes for which they should be held accountable.

The proposed organization would alter slightly some of the responsibilities of line and staff concerning the preparation of the MBO and ZBB plans which serve as the basis for the Short-Doyle Plan document. For example, we envision that the Mental Health System will assume more involvement in scheduling the timetable for Short-Doyle Plan completion. We also envision the Local Director of Mental Health as responsible for the presentation of the Plan to the Mental Health Advisory Board and the Board of Supervisors. Presentation of the Short-Doyle Plan to the Mental Health Advisory Board and Board of Supervisors has most recently been handled by an administrative support system (Program Planning and Development). Technical skills of budget development, evaluation, and plan checking for MBO consistency should, however, continue to be provided by administrative support specialist personnel.

Overall, the Department's planning efforts are quite commendable and we found no substantial problem areas greatly affecting plan development and outcome.

RECOMMENDATIONS

38. That the Department hold periodic reviews of its as yet unaltered overall goals, as well as the continued review of its specific program goals. These reviews should consider such factors as socio-economic developments, legislative changes, and shifts in private and public sector health services, and changes in Board of Supervisors Policy.

39. That lead responsibility for MBO and ZBB development remain with managers of the direct

service systems. Direct service systems, however, should take greater involvement in the scheduling of plan development and the presentation of plans to appropriate review bodies.

40. That the Administrative Services System support specialist personnel continue to provide technical assistance (budget development, evaluation, and plan checking for MBO consistency) to both Mental and Public Health Systems.

13. PROGRAM REVIEW AND EVALUATION

We examined the utilization of the Program Information and Evaluation Section (PIES) by middle and top level management for evaluation of programs.

The PIES was established in 1972-73. Currently, there are seven full-time equivalent positions in the Section (1 Evaluative Services Supervisor, 2 Program Evaluators, 3 Program Assistants, and 1 Typist Clerk). The functions and services PIES provides fall into four categories. Percentages of staff time devoted to each are as noted:

1. Compiling and interpreting program/service data and information for distribution to managers within the Department and others upon request (such as the various health advisory boards) (45%). This is an ongoing function and data flows to PIES from established computerized and manual systems. PIES staff also monitors data to assure quality of input and output related to those systems.

2. Designing and monitoring ongoing evaluation components for each program/service and State required client outcome assessment (20%).

3. Compiling data for the annual plan/budget and routine and one-time State and departmental reports and studies; designing and implementing consumer and provider surveys (15%).

4. Designing, implementing and following-up of major evaluation projects (20%).

There are approximately three studies per year of programs which are undertaken.

Providing Information

PIES manages the conceptual aspects of the automated Mental Health Management Information System (MH-MIS). This system

generates monthly, quarterly, and annual activity reports mainly about caseloads and therapist activities. Quarterly activity reports are required by the State under the Short-Doyle program. Activity reports are also provided to service chiefs, program managers, and top level management.

PIES maintains the quality of input data to MH-MIS through training of clerical staff in forms completion and other system procedures, and by answering questions and resolving problems, and redesigning input forms and report formats as needed.

Requests for data come from many sources and fall roughly into three categories: 1) information that requires a few minutes to obtain from existing report data (number of visits, people served, demographic distribution) and require no interpretation; 2) information existing in the data base but which requires hand calculations or computer programming to retrieve it; and 3) data which is not on the data base and must be collected and compiled.

PIES participates in the development of new data systems through identifying the data needed, designing the forms and procedures necessary for collecting the data, and developing the output format for the reports generated. PIES also monitors and reports data collected in the Public Health Nursing and Environmental Health Systems.

Program Data Monitoring

PIES continually reviews the MH-MIS output reports for accuracy to ensure utility by service chiefs. Through this review, program activity can be monitored and any significant deviations reported to service chiefs.

Review of Narrative Portion of Departmental Budget Request

One of PIES assigned responsibilities is the compilation and interpretation of data used in the Department's plan and budget. Program philosophy, goals, objectives, and activities are described in the narrative portion of the plan/budget. This has occurred because review of these elements serves as the foundation for program evaluation. As such, limited involvement in the plan/budget function is useful to evaluation activities. In addition to the narrative portions of the plan, PIES compiles and categorizes information regarding target groups, minority services, etc. for the budget.

Evaluations and Special Reports

Evaluations, reports, or special studies conducted by PIES are initiated generally under the following circumstances:

1. Upon request from top level management (Deputy Directors and above), middle management (program managers and service chiefs), other agencies, and assistants to service chiefs. The State Department of Mental Health also requests routine and special information -- some responses are simple, some complex.

2. Significant changes in program activity data. If a significant deviation in activity data is found, PIES tries to determine if the deviation is attributable to a recording error or reflects a real change in activity. If the latter exists, then PIES will confer with the affected program manager and/or Deputy Director to determine if an evaluation should be undertaken.

3. PIES may initiate an evaluation or study to address an issue that has significance to the scientific community at large, which also affects the Department.

To evaluate the distribution of reports managers receive from PIES, we analyzed the "Report Request Forms" file folder which lists the individual(s) requesting a particular report as well as to whom the report was distributed. The information below was tabulated from these forms which date back to 1974.

Total No. of Reports	Total No. of Copies Distributed	No. of Copies to Deputy Director Level and Above	No. of Copies to Program and Service Chiefs	No. of Copies to Others*
30	212	46	101	65

* The "other" category included staff not classified as Service Chiefs and certain task forces which, for purposes of presenting the data, were assumed to have five people each in them. Also included in the other category were State and other agencies and Department staff that could not be identified from the information available as Program Managers or Service Chiefs.

Of the total copies distributed, 47% of the copies were distributed to program managers and service chiefs, and 31% distributed to other staff or agencies. Twenty-two percent (22%) of the copies were forwarded to top level management. There was no way from the information available to determine whether reports received by managers below the Deputy Director level were forwarded to a Deputy Director.

Nevertheless, this data suggests that middle management receives greater feedback from PIES than does top management. This is consistent with the MBO philosophy of the Department which emphasizes line management responsibility. Greater feedback may also occur because middle management utilizes

PIES more than top management, since (from the same file folder) only 9 of the 30 reports were identified as requested by top level management. Of the remaining 21 reports that were requested by other than a Deputy Director(s), PIES directly sent copies of six reports to one or more Deputy Directors. There were 15 reports which appear to have been neither requested by nor distributed to Deputy Directors and above (50% of total).

There was no way, from the information available, to determine whether requestors in the middle management or other categories were acting upon orders or requests from Deputy Directors.

Top level management has not prepared a long-range plan and timetable indicating which programs are to receive a major PIES evaluation. Other than discussion around the current PIES workload, there have been no formal meetings of top management expressly to discuss long-range planning and prioritization of program evaluations. This would make it difficult for top level management's priorities to be translated into the PIES work plan.

PIES spends about 90% of its time providing information, studies and evaluations of mental health and substance abuse programs only. Of the 30 Report Request Forms, only seven were related to public health and environmental health programs. The amount of time spent in mental health programs is understandable since PIES grew out of mental health legislation. Also, costs of the unit are 90% offset by State funding for that portion of time spent working on mental health and substance abuse programs. Public health services are mostly County funded and do not have the financial leverage that mental health programs enjoy under Short-Doyle. Another approach to the selection of PIES studies is suggested in finding 14.

RECOMMENDATIONS

41. That top level management prepare a plan which selects and prioritizes future PIES evaluation projects.

42. As part of the preparation for each PIES evaluation study, as a minimum, the Deputy Director in charge of PIES and its unit supervisor should work with top management of the affected system or service to carefully define the purpose and objectives of the evaluation and specific questions they want answered.

14. UTILITY OF EVALUATIONS TO TOP MANAGEMENT

Section 5651(h) of the Welfare and Institutions Code requires that the County's Short-Doyle Plan include "A . . . description of the . . . quality assurance system of the county mental health program as required by Section 5624 and a description of any other evaluation activities of the county mental health program such as client outcome evaluation, measurement of the availability and accessibility of services, and client satisfaction surveys."

Section 4030 of the Welfare and Institutions Code requires the State Department of Mental Health to organize staff . . . "to assure implementation of the planning, research, evaluation and quality assurance responsibilities set forth in this Chapter."

Section 4031 of the Welfare and Institutions Code more fully defines the State Department's role and purpose regarding the "Planning, Research, Evaluation and Quality Assurance functions as . . . "(e) Perform any other activities useful to improving and maintaining the quality of State Mental Hospital and Community Mental Health Programs."

Section 5624 of the Welfare and Institutions Code elaborates further upon the relationship of quality assurance and evaluation activities and mandates "evaluation of the quality of care":

> "Each county mental health program shall establish by January 1, 1980, a quality assurance system that covers all county operated and county contracted mental health facilities and programs. As used in this section "quality assurance system" refers to a systematic approach for the evaluation of the quality of care which is designed to promote and maintain efficient, effective, and appropriate mental health services . . ."

Title 9, Section 772, of the California Administrative Code requires that "the Local Mental Health Service shall establish methods of evaluating the effectiveness of its program. This may be accomplished by personnel selected by the Local Director."

Title 9, Section 550(b), of the California Administrative Code defines evaluation services to mean:

> "1. Studies of the effectiveness and efficiency of specific programs in local mental health services in achieving the goals of the program and the

process by which such efforts are organized. Such management analysis will include studies of the relative cost and effectiveness of services and the efficient use of manpower, facilities and equipment.

2. Studies of the effectiveness or state of progress of the local community in achieving overall mental health goals or the process by which such goals are defined or pursued."

These code sections not only emphasize assessment of client status and evaluation of the quality of care (program), but suggest that evaluations can serve other purposes: meeting higher demands for accountability, keeping administrators and staff informed, justifying a program to grant agencies, planning more intensive studies, contributing to policy change or improved practices, and justifying elimination of undesirable program aspects.

We asked the Program Information and Evaluation Section (PIES) to indicate in priority order the most frequent use of evaluation reports they prepare. Keeping administrators and staff informed, evaluating programs because all programs should undergo evaluation, and contributing to policy change were noted in that order. Keeping administrators and staff informed as a first priority is somewhat supported by the previous data shown in finding 13 which indicated much greater use of PIES reports by program managers and service chiefs than by top level management.

Nearly all of the evaluative reports done by PIES are in mental health programs. The reason for this is that program evaluation functions grew out of mental health legislation and 90% of the costs for evaluative services in mental health is Short-Doyle offset.

We reviewed in detail nine evaluation reports (see Exhibit VIII) prepared by PIES and concluded generally, that they were approached more from a clinical orientation and less from the operational problem/solution identification orientation we would expect service provider managers, top level management or the Board of Supervisors to have. The reports concentrate on isolating and qualifying variables, and attempt to determine whether they impact program outcome.

Administratively-orientated program managers or governing bodies may be more concerned with their accountability for the efficient and effective use of public funds through the programs they direct. Because of this they would more likely be concerned with the efficiency and cost effectiveness of the practices that translate into program outcomes rather than program outcome and client status only.

While program outcome evaluations and operational analyses are both useful to program managers, the Health Department's concentration on outcome evaluations may in part be due to their participation with the State Department of Mental Health in its attempt to develop acceptable methodologies for clinical analyses. The State's priority has leaned toward effectiveness of treatment rather than cost-effectiveness of treatment. This emphasis may shift with a tightening of available funding.

We reviewed these reports for inclusion of criteria of interest to top level management as set forth in Title 9, Section 550 (b) of the California Administrative Code. The nine reports were also reviewed in general for methodology, format, and conclusionary information. The following summarizes the results of our review.

Analysis of Costs

None of the nine evaluation reports we reviewed included cost data on the program. Yet this is one of the criteria with which department management should be concerned and which is specified in Title 9, Section 550(b) of the California Administrative Code.

In 1973-74 the State conducted a pilot cost-effectiveness study on mental health services and Fresno County was one of five counties selected to participate. The Department reports that while the pilot study yielded no useful model for the Department, it did serve as a basis for development of cost information data associated with client outcomes. This data reflects a three-and-one-half year history of client outcome costs.

Exploration of Alternatives

Another interest of management should be the search for and evaluation of alternatives that might improve program cost effectiveness. One technique is to compare Fresno County services to similar programs conducted in other counties.

Of the nine evaluations we reviewed, one dealt remotely with comparison of outcomes of other county programs to those of Fresno County (Precision Study of Lab Results for Environmental Health, Water Surveillance). The remaining eight evaluations did not address alternatives to carry out a program.

The Health Department's policy has been not to include identification of alternatives as a component of its evaluation studies at the PIES level of involvement. It was felt that this was a responsibility of program managers and/or top management because evaluation staff's expertise

did not extend into the clinical or administrative fields which is necessary to recognize alternatives, estimate fiscal impact, and analyze legislative constraints.

Explicit Recommendations to Management

Of the nine evaluations reviewed, only one (Methadone Maintenance Program Evaluation) contained an explicit recommendation -- to reassess the goals of the methadone maintenance program. The remaining eight evaluations contained no explicit recommendations. This does not mean that recommendations do not result from the evaluation reports. PIES does discuss results and conclusions of the evaluation with appropriate management personnel and recommendations may result from these verbal discussions. This is consistent with the Department's philosophy concerning the responsibility of program managers, rather than evaluators, to identify alternatives and take appropriate follow-up actions. Nevertheless, the need for explicit recommendations is an item of which management should be apprised -- and identification of that need should be noted, encouraged and supported in the evaluation report to ensure management is aware of potential follow-up action, and to stimulate consideration of those possibilities.

Methodology and Format Reflect a Scientific Orientation

Evaluation of human services programs is relatively new. Its methodologies are taken from those approaches characteristic in social science research. Criteria are strictly defined so as to preclude the possibility of misinterpretation, or repeating deficiencies which occurred in previous evaluation methodologies of the same or a similar program. Conclusions of the evaluation are strictly limited within the scope of the specific criteria evaluated.

One example is the "Methadone Maintenance Program Evaluation Report". It was an evaluation of patient outcome compared to the program's patient outcome goals. Its content shows a high degree of professionalism in methodology, presentation of data, and conclusions. Its approach is similar to articles one would find in academic social science journals. The purpose of the methadone maintenance program evaluation was to determine whether client results reflected the goals to be achieved in methadone maintenance. These goals were:

1. Reduced heroin dependency.

2. Reduced criminal behavior.

3. Increased employment.

The conclusions of the evaluation were:

1. That goals of the program were unrealistic given

the admission criteria to the program

2. That measurements used to assess client outcomes were not sensitive enough to measure any significant changes strictly attributable to the program.

Although the report contained an explicit recommendation (to reassess the goals of the program in light of admission criteria), it did not elaborate on any specific recommendations for management to improve the effectiveness of the program. If the goals are found to be unrealistic, realistic goals should then be proposed by the evaluation staff for consideration by those most knowledgeable about the program and its clients. Required legislative action, if any, should be identified. Regulatory parameters to altering goals without losing State financial support should be specified. Available alternatives that could improve effectiveness or reduce cost without significant loss of income should also be explored. Comparisons of internal program methods with those in other counties should be discussed.

The report, however, because of its rigorous scientific orientation, does not, nor would be expected to address the values, criteria, and concerns of managers or political officials with administrative or operational responsibilities. Furthermore, it is doubtful that top level management would find this evaluation alone sufficient to redesign or modernize the program, or change policies or administrative practices.

RECOMMENDATIONS

43. That future evaluation studies also address issues that, once examined, can assist in improving the cost effectiveness and efficiency of programs, and the efficient use of manpower, facilities, and equipment (CAC Title 9, Section 550). This will require top management to modify its approach to ensure evaluations address administrative and operational issues along with program and client outcome issues. Top management should work with PIES to determine the purpose of each evaluation, the approach, the scope of staff expertise required for the study and evaluation criteria including those spelled out by law and regulation along with additional criteria management wishes included.

44. That the administrative and operational elements of evaluations be conducted by the proposed Budget and Staff Services Section as recommended in finding 2 on Organization of Administrative Support Systems. Two of the three positions in that

section are offset by deletion of two positions in PIES. This will enable the Department to reallocate resources to ensure the availability of administrative and analytical staff expertise to evaluate program alternatives, cost effectiveness, and efficiency issues.

45. Once PIES studies begin to help managers achieve cost savings and measurable efficiency improvements, as well as clinical effectiveness, the selection of PIES assignments and priorities should be made less on the basis of the degree of revenue offset of their salaries when applied to a particular program than on the total potential for savings in program costs that may be achieved.

EXHIBIT - VIII

EVALUATIONS REVIEWED BY MANAGEMENT SERVICES

Program Evaluation of the State Department of Vocational Rehabilitation Cooperative Contract, (June, 1978)

Client Satisfaction Study - Adult Day Treatment Services, (December, 1976)

School Resources Officer Program Evaluation, (August, 1977)

Public Health Information Project, (May, 1977)

Primary Mental Health Project Evaluation, (July, 1978)

Precision Study of Laboratory Results, (July, 1977)

Methadone Maintenance Program Evaluation, (January, 1978)

TV Spot Evaluation, (July, 1976)

Community Service Study of Crisis Service, (July, 1978)

15. QUALITY ASSURANCE

"Quality assurance" (QA) refers to organized efforts to ensure competent clinical practices in health service programs within the Department. Under this definition, a number of activities could be considered as quality assurance related--program evaluations, review and improvement of treatment practices and methodologies, certain patient advocacy activities, monitoring of medications administered to clients, design and maintenance of patient care facilities, utilization review, and day-to-day supervision of health service programs.

Quality assurance in some form or another has always existed for health services delivery. For example, the Joint Commission on Accreditation of Hospitals (JCAH) makes biennial surveys of the Health Department inpatient facility. They review operations, facility design, whether some clinical practice review takes place, and examine other criteria for accreditation purposes.

Another form of QA for health services is the Professional Standards Review Organization (PSRO). PSRO's grew out of Federal legislation (the Bennett Amendment to the Welfare Reform Act) and their purpose is to ensure checks and balances of clinical practices at the local level. PSRO's are area organizations which are establishing standards and reviewing practices in clinical treatment of disorders. The PSRO for this area is the Fresno-Madera Professional Review Organization, Inc. Membership is open to any doctor in the area. Opinion is divided as to whether PSRO's represent a significant enhancement in QA. A 1977 Federal Health Services Administration study of the PSRO networks concluded that its impact was minimal according to an article from the December, 1978 issue of "Drug Therapy."

Effective July 1, 1978, the State required utilization review (UR) in acute hospitals within the Short-Doyle/ Medi-Cal system. Utilization review, as an element of QA, is the review of the admission and length of stay of inpatients for given diagnoses of disorder. The purpose of UR is to ensure against payments by Medi-Cal for unnecessary psychiatric services rendered to patients. The State has established criteria for inpatient admissions and time periods that Medi-Cal eligible individuals with a given disorder diagnosis normally require acute psychiatric hospitalization. The State requires that counties keep utilization review records for future audit purposes. These records contain certain information pertaining to patient admission, diagnosis, treatment plans, prognosis, discharge, and outcome.

The Psychiatric Inpatient Service has established a UR procedure for all admissions and for cases which exceed the allowed days in the unit. A reviewer from outside the service checks each chart to see that documentation justifies admission or extension of days. In addition, a peer review team consisting of a psychiatrist, Psychiatric Social Worker and Mental Health Nurse reviews records of each attending psychiatrist on a monthly basis to determine quality of care, record completeness and utilization review.

Two multi-disciplinary peer review teams, consisting of five people each, have been established for outpatient and partial-day programs. Each team reviews approximately 20 randomly selected cases each month. Their main emphasis is utilization review, however, they also do record review and quality review. The State is developing guidelines for utilization review which may greatly affect the number of records that are reviewed.

Medicare "Conditions of Participation" regulations also require utilization review in the Home Health Agency. This agency utilizes an internal UR committee as well as an external UR committee. They keep minutes of all meetings and summaries of findings of the follow-up activities. The decentralized clinics have implemented a peer review process based on protocols established by their clinicians. The purpose for the peer review is primarily improvement in the quality of care through staff education. They also look at record completeness and utilization.

At the close of the 1978 regular session of the State Legislature, the Governor signed into effect AB 3644. This bill establishes planning, research, evaluation and quality assurance responsibilities within the newly recreated State Department of Mental Health.

The Bill also requires each county mental health program, by January 1, 1980, to establish a quality assurance system covering all county operated and county contracted mental health facilities and programs. The term "Quality Assurance System" refers to a systematic approach for the evaluation of the quality of care which is designed to promote and maintain efficient, effective, and appropriate mental health services.

The County's mental health QA system is to include at least:

1. Utilization review of all Short-Doyle funded inpatient services.

2. Interdisciplinary peer review of the quality of patient care.

3. Monitoring of the medication regimens of Short-Doyle

clients. This includes (among other items) procedures to review appropriateness of the medications prescribed and their effectiveness, dosages, occurrence of any adverse reactions, the extent of patient compliance, and patient ability to manage his own medication regimen.

The State is required, by July 1, 1979, to provide guidelines to counties concerning implementation of these functions.

The Department began developing the basis for a QA system well in advance of the Bill's passage to meet the inpatient requirements and the proposed outpatient and partial day requirements under Short-Doyle/Medi-Cal. The Director of Public Health Nursing has had lead responsibility for coordination of QA development since her appointment to that position in February, 1978.

The Department has conducted one medication audit and one re-audit. Some minor problems were found and corrected. It should be noted, however, that setting "standards" for medications may be a difficult task in that appropriate dosages and types of medications may vary with individuals showing identical diagnoses.

On January 15, 1979, the Board of Supervisors approved the submission of a grant application in the amount of $210,952 to offset completely the costs of providing utilization review for mental health within the Department. This grant is still pending and there is no assurance that it will be obtained at this time.

Since State guidelines have not yet been developed for the level or frequency of mandated QA system activity, it is premature to determine accurately the amount of staff time (existing or additional) necessary to meet legal or regulatory requirements.

The Department has made a commendable effort to establish a mental health QA system. We feel that its continued development is necessary to meet the January 1, 1980 deadline for implementation. However, care must be exercised to ensure that public health quality assurance efforts receive appropriate attention as well.

We also feel that a full-time position will be necessary to coordinate the development and administer the QA program. This entails: 1) monitoring the activities of utilization review within mental and public health; 2) ensuring that peer review activities/sessions are conducted regularly; 3) working with health professionals to establish peer review criteria; 4) ensuring that medication regimens monitoring criteria are developed where required and monitoring is taking place on a regular/periodic basis; 5) preparation of such reports that the State requires under

regulations and guidelines yet to be developed.

The coordinative development of a quality assurance system can be accomplished using a staff position. We propose placing the QA coordinative responsibility within the Information and Evaluation Services Division as recommended in finding 2 on Organization of the Administrative Support System. Quality assurance is a major resource of the Department's top level management, and placement of the coordinative function in this division as proposed will provide for immediate and continued feedback by its proximity to other information services units.

RECOMMENDATIONS

46. That a new position of Quality Assurance Coordinator be created in the Department with assigned responsibility for coordinating the development and administration of the Department's QA system.

47. That the responsibility for administering the Department's QA program be placed within the proposed Information and Evaluation Services Division.

16. MANAGEMENT PRACTICES

This finding examines the management practices in use by the Department through June 30, 1978. Discussed here are the Department's management style and the decision-making process.

Matrix Management

In 1974, matrix management was instituted in the Department by the Director. Matrix management is an approach that formally recognizes the existence of the informal organization as the viable mechanism to accomplish project tasks and objectives. Its most striking characteristic is that because some managers report and/or relate to two or more superiors, peers, or subordinates for different assignments or different aspects of their responsibilities, participation is greatly enhanced.

We surveyed 45 managers (Deputy Directors, program managers, service chiefs) in the Department about management style and symptoms that would indicate possible problem areas. Top level management was excluded from the survey because we wanted to focus our attention on the mid-management group.

Based upon the survey information, we concluded the organization of the Department was a sometimes contradictory mixture of a loose pyramid, a matrix, and participative management style-structure. Emphasis of one approach or the other appeared to vary depending upon the scope, urgency, or importance of the task, or the interest of the Department Head or other managers. The Department made heavy use of committees and task forces to accomplish major tasks or projects.

There are a number of positive aspects to both participative and matrix management--more considered decisions from greater involvement and input by staff responsible for task completion; learning opportunities to participate in the decision-making process by staff who otherwise might not have that opportunity; the gaining of general management experience in areas beyond particular expertise of the participant; the opportunity to make contributions in areas outside the manager's particular area of expertise; and encouragement of initiative and motivation through the team approach to meeting objectives. These all serve to enhance the professional growth of the manager.

On the negative side, there are a number of possible pitfalls inherent in the Department's management style-structure which, if not avoided, can be counterproductive to effective management. These include vague specification of responsibilities, overlapping or fragmented authority and responsibility, initial preoccupation with internal processes at the expense of attention to service delivery issues (usually occurs with newly-formed matrix structures), territorial struggles, frequent upward referral of issues to resolve conflict, needless clearance of decisions by managers unfamiliar or uninvolved with a particular project, and the feeling that there is too much democracy and not enough decisiveness under matrix management.

Appraisal of Matrix Management in the Department

We believe the Department was successful in reaping many of the positive benefits to be gained from these management styles, as described above. However, from the survey mentioned above, managers reported many of the pitfalls of these management approaches have been present in the Department of Health. These are outlined below:

- Overlapping Boundaries - Twenty-four (53%) of the managers felt that boundaries of authority and responsibility overlapped within and between systems while 12 (26.5%) of the managers did not. Seven managers had no opinion or no response. In addition, 69% of the managers indicated that they had no documents which defined their management responsibility and authority or defined their relationship

to other managers when undertaking various tasks or projects.

Under these conditions, certain tasks or responsibilities are likely to be only partially addressed or "fall through the cracks." Also, without clear task and role definition, delays can occur when managers begin to take on critical issues and must try to first sort out who has lead and who has support responsibilities. Functional relationships between managers should be explicitly detailed so that people are in agreement about who is to do what under various circumstances.

- Considerable Management Autonomy - We asked managers to indicate their degree of agreement or disagreement to the following statement in the questionnaire. "Most of my activities, services, or major projects are directed from higher level authority within the Department." Twenty-seven (60%) did not feel that their activities were directed from higher level authority within the Department while eight managers (18%) felt otherwise. Ten managers (22%) had no opinion or did not respond to the question. Management autonomy can be viewed as positive or negative under varying conditions. If considerable autonomy takes the form of latitude in the way managers allow subordinates to accomplish their directed tasks, goals, and objectives, then this can be quite positive because it elicits initiative, motivation, and job satisfaction. If, however, management autonomy is the result of little or no executive management direction, review and control, then too often the manager's efforts may stray from contributing or may even be counterproductive to the Department's priorities and mission. There are many consequences of this kind of condition: unresponsiveness, tendencies toward "anarchy", isolation of top managers from conditions in line operation, feelings by middle managers that top management is of little or no contribution to running the organization, greater difficulties in completing team tasks which require cooperation, and delays or failure to detect and correct mistakes or problems.

- Existence of Territorial Struggles - Thirty-two (73%) of the managers felt power struggles existed within the Department at middle and upper levels. Five (11%) of the managers did not feel that there were power struggles within the Department and eight (18%) had no opinion or no response to the question. While territorial struggles exist in most organizations, under a matrix management approach power struggles are virtually encouraged or expected. A

central attribute of matrix is multiple chains of command and overlapping authority. Under this situation power tends to shift from one task to the next, and managers tend to compete constantly for the authority to carry out their assigned, perceived or desired responsibilities. For matrix to operate effectively there has to be a defined distribution of authority so that devisive struggles to define "turf" do not take place. Apparently, the mechanisms to check these struggles was not strong within the Department.

- Preoccupation in Internal Processes - Twenty six (59%) of the managers surveyed felt that managers tend to get absorbed in internal processes at the expense of attention to service delivery, while 13 (29.5%) felt that this did not occur. Six had no opinion or did not respond to the question. Because a matrix style creates interdependence of managers and tasks, it demands a good deal of negotiating. Managers sometimes tend to get absorbed in internal affairs at the expense of paying attention to service delivery. When this happens, managers can spend more time ironing out disputes than in facilitating service to clients.

Because of the biases inherent in opinion surveys, (i.e., individual differences in perception of the question and degree of response), we can't draw absolute conclusions about the data. Nevertheless, the data does suggest that elements of the negative aspects of matrix and participative management exist in varying and perhaps substantial degrees within the Department.

Decision-Making Process

The Executive Staff Committee was comprised of the Director, Associate Director, Drug Abuse Director, and the six system Deputy Directors within the Department. It is this body that has guided the Department. Meeting as a group, these managers exercised overall management authority for the Department, determining courses of action on matters confronting them on their weekly agenda. Sometimes the former Director chose to preempt executive staff with certain matters he was interested in.

Executive staff delegated certain day-to-day administrative responsibilities to their respective staff assistants, who made up a group known as the Administrative Staff Group (see finding 17). The delegated responsibilities entailed developing "short-range strategies, tactics and operations" necessary to implement administrative goals; establish total systems, procedures and processes necessary to implement goals; provide feedback to the Executive Staff

Committee regarding the effectiveness of systems, issues and problems. The reason for Executive Staff delegation of these tasks was to allow them the time to deal with the broader policy issues. Broader policy issues refers to matters which cut across and/or affect most systems in the Department.

A review of the Executive Staff minutes for the past year, however, indicated that there were very few issues which came before the Committee that could be categorized as having broad policy implications affecting most systems within the Department. More often, this committee heard and acted on items that were narrower in scope such as: approving and disapproving specific proposals, projects, and grant applications. These decisions were all made by committee consensus with majority rule.

Since the Department reorganization of top management approved by the Board of Supervisors on June 12, 1978, Deputy Directors represent the top end of middle management. Their primary responsibility is now the management of the system to which they are assigned. The Associate Director of Health for Administration, the Health Officer, and the Mental Health Director have primary responsibility for advising the Director of the Department on overall management and policy issues that affect the systems each Deputy Director manages, as well as to carry out the directives of the Director in operating the Department.

This basic organizational change, and the additional clarifying adjustments recommended in this report, are intended to free middle managers to devote more time to management of the day-to-day activities of their divisions. These important management functions include: short and long-range planning; organizing resources to accomplish tasks efficiently and effectively; directing operations to accomplish established system goals and resolve problems; monitoring progress; and select and ensure training of key staff.

RECOMMENDATIONS

48. That the Director and his immediate executive subordinates see that the energies of middle and lower management be concentrated on the efficient and effective execution of their programs.

49. That top management utilize middle and lower level managers as valuable information resources for top level decision-making. It seems especially important in the highly technical field of health care that middle managers be developed into and utilized as program experts. In concentrating

the responsibilities for top policy review and advice to the Director among the Associate Directors, the Department should recognize these proposed changes do not exclude middle managers from giving input into decisions. These managers should continue to provide input, but it should now predominantly be advice on the effects of policy and various other issues on their particular program or administrative area of responsibility.

50. Care should be taken in transitioning the Department from its broadly participative management approach to this new emphasis on categorical responsibility. Top management must actively solicit and encourage middle and lower level management input and initiative. Otherwise, these personnel may come to feel alienated from the management process by this narrowed, but more intensive focus of their participation. Their temptation to withdraw from interaction with the Associate Directors could aggravate the isolation of top management from department operations.

17. USEFULNESS OF COMMITTEES

The Department has utilized staff groups and standing committees to provide a forum for discussion, provide training, facilitate communication, and to address specific problems.

Management Group

The main staff group formed was the Department of Health Management Group. This group, formed in December, 1975, was also known as the Group of 80 because it consisted of up to 80 personnel including Deputy Directors, their secretaries, and middle and lower management levels such as program directors, service chiefs and Administrative Services Assistants. This group met on a monthly basis until October, 1978 when regular meetings were suspended.

The purpose of the Management Group was to provide a forum for discussion and exchange to facilitate formal and informal communications among management and staff; provide training in management skills; clarify, coordinate and develop possible solutions and policies to address issues and problems; and promote goal development, review and progress monitoring.

Topics of discussions and reports included zero base

budgeting and the move to the Mall. Training presentations on topics such as career development, time management, and management styles were held at the meetings. Generally, the meetings lasted from 8:30 a.m. to 5:00 p.m. and there was time for open discussion and a report by the Director. From July 1, 1977 to July 1, 1978, only one written report (an informational three page memo) was sent from the Director's Office to the Group of 80. This report was on organizational issues.

A six member steering committee of the Group of 80 was responsible for preparing an agenda and organizing the programming for the Group of 80 meetings. Its membership was elected by the Group of 80 on a regular basis. Every six months, three new members were elected.

Administrative Staff

The second main staff group is the Administrative Staff. This group is composed of Administrative Services Assistants and Chief Clerks. It was formed in February, 1976 and its main purpose was to establish and implement uniform administrative procedures; solicit input from departmental staff on administrative issues; and develop clarifying administrative policy where policy had not been set (subject to executive staff approval).

This committee is primarily a method of developing more routine administrative matters such as procedures for performing various clerical functions that are common within all the divisions of the Department. The committee was not formed to address any specific issue or formulate solutions to specific problem areas. However, they were assigned as the budget task force. This responsibility included assuring uniformity in the budget process and communicating budget information between the various sections of the Department.

Personal Health Staff

The third main staff group was the Personal Health Staff Committee. This committee was formed in May, 1976 to review any problem areas of a clinical nature that were generally common to several different programs. Its membership consisted of representative middle managers from the direct services and some clinical staff support personnel.

While its exact purpose and specific goals were vague, it did receive some assignments from the Department's Executive Committee and the Director and had some accomplishments. It was able to develop a continuity of care plan to ensure continuous and appropriate care for patients transferred among programs within the Department. The

committee also assisted in developing elements of a quality assurance program which monitors the quality of client care. The committee recently (October) suspended regular meetings until further specific assignments are made.

Appraisal

These staff groups are the major identifiable consumers of management meeting time, but are by no means the exclusive meeting activities of the Department. Other meetings included service chiefs and Associate Directors, program staff meetings, division staff meetings, and advisory board meetings. They illustrate a definite pattern of extensive regular meetings as a management technique utilized by the Department of Health.

As part of our review of the time spent at meetings, we surveyed by use of a questionnaire, 72 supervisory and management positions. Many of these individuals regularly attend standing committees, staff group meetings, conferences and general business meetings. Our survey covered a one month period from March 1 through March 31, 1978. The results of that survey indicated a significant percentage (23.2%) of available working hours were spent in conferences and meetings. Based upon the monthly salaries of these staff personnel, the approximate cost of staff attendance was $31,345 for this one month. Projected full-year costs would be $376,140.

The Department has shown little reluctance to rely heavily on staff groups, committees, and meetings to solicit ideas, share information, formulate proposals and attempt to receive input and participation in the management of the Department at all levels. While many meetings have been guided by memoranda and agendas, written communication could receive considerably greater use. These mechanisms are much less expensive and can also be more precise, accurate, thorough, organized and provide a good source for future reference and guidance. Nevertheless, written communication should not take the place of verbal communication or group processes which facilitate the open exchange of ideas. A balance of both types of communications should be used.

While standing committees and staff groups are beneficial in improving and maintaining communications, the amount of time spent in these meetings and conferences should not be so extensive that they can materially restrict the available time of management personnel to operate assigned programs and perform their various duties. Meetings are an expensive form of communication and should be utilized judiciously, and not to the exclusion of less expensive alternatives.

RECOMMENDATIONS

51. The Department should encourage its staff to generally reduce its use of conferences and meetings for general purposes.

52. Be more selective in deciding which classifications to include in staff meetings, such as the Group of 80 monthly meetings.

53. Rely more on other channels of communications such as reports, memos and directives in lieu of committees.

54. Place a definite time and task objective on the life of special staff groups or committees. Chairpersons should provide similar objectives for each meeting.

55. Ensure that goals/objectives of committees are explicitly stated, realistic, and can be accomplished in a minimal and specified amount of time.

56. Stress the responsibility of all personnel who convene meetings to properly prepare in advance so that business can be conducted swifly yet completely. Also stress the responsibility of meeting attendees to prepare in advance for meetings so that their familiarity with the business at hand will also expedite attaining meeting goals. Advance distribution and review of agendas and background material are useful mechanisms.

SECTION V. FINANCIAL MANAGEMENT

18. FINANCIAL MANAGEMENT OF THE AIR POLLUTION CONTROL DISTRICT

The full costs of the functions of the Air Pollution Control District (APCD) have been budgeted in a special district budget unit since 1971-72. All appropriations are fully offset by revenues from the Environmental Protection Agency (EPA), Air Resources Board (ARB), fees, fines, reimbursement for contract services to other counties, and the County General Fund contribution to the District. Revenues are deposited in the APCD Special District Fund as received.

The Environmental Health System of the Department of Health administers the Air Quality Program. The direct costs of operating the program are also appropriated in its budget. This is a County General Fund appropriation. All direct Air Quality Program costs are charged to this appropriation rather than to the APCD budget (with the exception of Hearing Board members per diem and refunds to fee overpayments). The County General Fund is reimbursed by the APCD budget to fully offset those expenditures plus departmental and County overhead costs. These latter two items are allocated costs appropriated and incurred by the General Fund outside the Environmental Health System's air quality cost center, but which are attributable to the air program. Revenues equal to the total of these County General Fund costs are transferred to the General Fund from the Special District Fund on a monthly basis (irregularly prior to May, 1978).

Fund Balance

Over the years an available fund balance has accumulated in the APCD budget because overall revenues have exceeded reimbursement transfers of revenue posted to the General Fund that were needed to offset actual direct and indirect costs of the air program. An available fund balance is a term in the Government Code which refers to that portion of a fund balance which is free and unencumbered for financing the program of expenditures and other requirements of the fund. On June 30, 1978, this available fund balance totaled $79,140. The following tabulation shows how this balance has accumulated in recent years:

Fiscal Year	District Revenue	District Expenditures and Transfers to General Fund	Difference	June 30 Available Fund Balance	Interest Revenue
1977-78	$433,423	$466,475	$(-33,052)	$ 79,140	$14,702
1976-77	448,961	406,575	42,386	112,192	11,703
1975-76	397,111	356,049	41,062	69,805	13,134
1974-75	308,303	280,101	28,202	28,743	15,987
6-30-74	--	--	--	541	--

The APCD's available June 30, 1978 fund balance as identified by the Health Department's accounting system consists of total cash on hand ($146,162) less accounts payable to the General Fund for June, 1978 costs ($34,245) and encumbrances for prior year appropriations ($32,777) on the last day of the fiscal year. It does not include anticipated revenue earned during 1977-78 that had not yet been received. Consequently, the fund balance figures above understate the APCD's liquidity by excluding revenue that could be accrued as of June 30, or in other words, that will be received after June 30 as a result of operations in the fiscal year ending June 30. If anticipated revenue were accrued as of June 30, 1978, the APCD available fund balance would total $144,263. This additional $65,123 over the $79,140 shown above consists of the following:

Source	Month Received	FY Earned	FY Received	Amount
EPA Grant	August	1977-78	1978-79	$34,528
ARB Grant	August	1977-78	1978-79	26,580
Madera County	July	1977-78	1978-79	2,722
Stanislaus County	July	1977-78	1978-79	1,293
			TOTAL	$65,123

Under the "Uniform System of Accounts for Special Districts" promulgated by the State Controller, revenues are to be recorded when received as cash except for revenues susceptible to accrual at the close of the fiscal year. That susceptibility applies to anticipated revenues which will be available to finance County expenditures, those based on services already performed, and which are considered fully collectible. Under these guidelines, anticipated APCD revenues from EPA, ARB, and other counties can be accrued.

The accruals of these anticipated revenues would permit a more accurate representation of the annualized financial condition of the District. It would also make a one-time revenue lag of $65,123 available as a financing source for District operations.

The Health Department budget staff has in some years underestimated revenues and overestimated requirements in calculating the amount of County General Fund contribution needed to balance the APCD Special District Fund budget. For example, revenues have been underestimated by disregarding interest earnings on the APCD fund balance. This amount should have been minor, but has been substantial since the Health Department Accounting Section was up to 11 months behind in reimbursement transfers from the APCD Special District to the General Fund. This allowed a continuing high APCD fund balance sometimes in excess of one-third million dollars, at the expense of the General Fund cash position and interest income. Since May, 1978 the Accounting Section has been reconciling the APCD budget with the General Fund air program costs, and has been making reimbursement transfers to the General Fund, on a monthly basis.

The Accounting Section has also transferred all budgeted County contribution funds to the APCD, consistent with provisions of Section 40101 of the Health and Safety Code, regardless whether the entire amount was needed to pay for all District obligations for the year. The Board of Supervisors, having general supervision and control of the financial affairs of both the County and the District (White v. Mathews 29 CA 634), has the authority to cancel specific appropriations of the General Fund such as the contribution to the District, as long as the appropriation is not required to meet the District's obligations for the current fiscal year (Government Code Section 29130). In this way an excessive contribution appropriation may be withheld from the District after the budget is adopted, if overestimated during the budget process in the first place.

We have not found any District surpluses returned to the General Fund since 1972-73. At that time, the fund balance was distributed to the Federal government and the County. A possible advantage of the appropriation cancellation approach is to avoid any confusion over whether grant funds are being used for other than air pollution control purposes. Once the County's contribution is mingled in the District's funds, its identity as distinct from grant funds is obscured. A return of excess County contributions could therefore be interpreted as an inappropriate distribution of Federal funds.

Requirements have sometimes been over-estimated due to the

practice of estimating salary increases for the budget request without going back in final changes to adjust for actuals. For 1978-79, funding for estimated salary increases was left in the budget despite the prohibitions of SB 154.

Capturing All General Fund Costs

The Financial Management Information System (FMIS) reports of the Auditor-Controller provide for the accumulation of General Fund direct costs of the air program for which the Health Department bills the APCD. An exception is some relatively small office expenses not spread by FMIS to the various cost centers and which is allocated through a manual system to the air program.

During the course of our review, we noted a microbiologist in the Public Health Laboratory is charging substantial time to the air program (approximately half). This cost amounts to about $10,000 per year and is not budgeted in the air program as a direct cost. The Accounting Section has not been picking up these costs off the FMIS as direct costs to charge to the APCD. The Public Health Laboratory costs are considered a direct cost rather than indirect in developing the Department's overhead rate which is used to apply indirect costs to the air program. Consequently, the General Fund has been absorbing this portion of the legitimate charges against the District.

Grant Application Budgets

The APCD budgeting process also includes preparing a complete District budget for the grant applications to ARB and EPA. The budgets for these applications are prepared a few months prior to the year for which they apply, but usually after development of the Department's County budget request. As a result, changes do occur between the time the grant application budget is prepared and submitted and when the Board adopts the final General Fund Health Department budget and final APCD Special District budget. This causes some confusion for air program staff since the changes are usually initiated by the Department's budget office, Department management, and/or the County Administrative Office to conform to department-wide financial considerations. Air Quality staff must in turn explain the changes to the ARB and EPA to request a grant budget adjustment. This is especially important in the event of downward revisions where County maintenance of effort is needed to preserve the EPA grant.

The EPA has threatened to reduce or withhold the 1978-79 grant because changes to the 1978-79 Health Department and APCD budgets since the grant application have raised questions of maintenance of effort. For 1978-79, the

Department imposed a 4.5% salary savings on each of its General Fund cost centers to meet budget ceilings.

The air program's General Fund budget allocation reflected this reduced allocation. Nevertheless, it was a department-wide reduction to be attained by holding vacancies after turnover. No particular Health Department program was required to meet this allocation goal since the location of attrition can't be predicted accurately. It was therefore inappropriate for the grant budgets or APCD budget to also reflect this 4 1/2% salary savings. The air program does not anticipate any turnover nor a reduction in its total program effort for 1978-79.

While it is necessary that the Health Department's Air Quality Program cost center budget conform to the Department's total General Fund budget, and that the APCD Special District budget agree with the EPA and ARB grant application budgets, the air program cost center and APCD budget need not agree in every particular. This is especially true where the air quality cost center budget is altered to conform to Health Department budget ceilings while the APCD budget is expected to reimburse the General Fund for all expenditures including foreseeable overruns of the air program cost center. The APCD budget and grant application budgets should be exempt from adjustments which do not realistically reflect actual program expenditure and revenue expectations within staffing and work goals approved by the Air Pollution Control Board.

The EPA and ARB expect that the budgets in the grant applications are the official budget adopted by the Air Pollution Control Board for the APCD. However, the Health Department has not utilized APCD budget figures in the information it supplies to EPA and ARB. Instead, it has been a composite of the Health Department's internal budget targets for the General Fund budget air quality cost center, other cost center direct costs applicable to the air program, Health Department overhead figures, and APCD direct costs. These figures can and do change both before and after the APC Board adopts the Health Department General Fund budget. As such they are not official appropriations as prescribed in Section 29000 et. seq., Government Code, and therefore are not appropriate for use by grant agencies. We also noted inconsistencies in reports of actual APCD costs given the EPA for FY 1977-78 by various units of the Health Department.

We attribute most of the Department's confusion over budgeting and accounting inconsistencies to the dispersal of financial responsibility for the APCD between Environmental Health, Program Planning and Development and Financial Services. This issue is dealt with directly in finding 2 and partially below.

Financial Information

Financial management information on the APCD provided to Environmental Health program managers is incomplete. Without regular and complete reports, Environmental Health System management cannot be held accountable for the financial status of the APCD.

The FMIS Departmental Work Plan reports provided them do not show salary costs, some services and supplies expenses such as postage and photocopying, nor overhead charges. The Accounting Section has or can obtain this omitted data to supplement the FMIS Work Plan report so that the total picture of expenditures and revenues to the air quality cost center and APCD can be readily identified. However, the format in which this information is currently summarized needs to be improved by separately reporting General Fund costs and APCD costs. The Auditor-Controller's comment at the end of this finding identifies additional improvements that should be made in maintaining the accounts of the APCD and the General Fund air quality cost center of the Department of Health.

In 1976-77, the Accounting Section posted the APCD's encumbrances as a District expenditure in June; while for 1977-78, this encumbrance has been carried over as a prior year expenditure for 1978-79. This inconsistency tends to misstate the District's comparative financial situation from year to year.

During the course of our review, we discovered that the Accounting Section was unaware that any 1977-78 reimbursement revenue from Madera and Stanislaus counties had been received for the APCD. While the funds were properly credited to the District, the Accounting Section misidentified them as permit fees and reflected them as such in their District financial report. This situation indicates a lack of deposit and/or invoice reconciliations to verify that the revenue was properly credited to the District. Better coordination is needed to see that the District's financial affairs are budgeted and accounted the same way.

Financial Management

During the course of our review, we found no one in the Department of Health fully conversant with the financial management of the APCD. We did find an abundance of people who had a role in partially managing the District's finances. We also found their knowledge of the process, as well as status of finances, limited and at times inaccurate.

The positions we found having an active role included the air program's Supervising Sanitarian and Senior Environmental Engineer, an Assistant Director of Environmental Health, the Director of Environmental Health, a Chief Clerk,

an Accounting Section Accountant and an Account Clerk, other Financial Services System staff, a Budget Section Research Analyst, and another staff person from the Program Planning and Development System.

Some distinction should be made between participation and management. A number of people quite properly should have input into the District's financial management as participants. However, only one person can be assigned management responsibility for seeing that all District financial business is properly carried out by the "participants," and see that policy issues are properly presented to top management and the Air Pollution Control Board.

This management responsibility should be assigned to the lowest responsible manager who has the time, experience, understanding and authority needed to carry it out. We believe that level to be the Assistant Director of Environmental Health. The Supervising Sanitarian needs to have more time available to supervise the activities of field staff, and the pattern of assignment we envision here would permit this to occur (see finding 4 on Organizational Placement of the Air Quality Program). The Director of Enviromental Health needs to have more involvement to exercise his broader responsibility for performance and control of the District, but he would not have the time for the detailed responsibility of financial management because of his responsibility for all environmental health programs.

RECOMMENDATIONS

57. That the Health Department budget staff consider the anticipated APCD fund balance as a financing source when preparing its Health Department and APCD budget requests as provided by Section 29143 of the Government Code. This would reduce the County General Fund contribution required to balance the APCD budget. The Health Department should provide to the Auditor-Controller, and the Auditor-Controller should reflect, the available fund balance in the proposed and final budget documents as a financing source for the APCD.

58. That the Board of Supervisors, as authorized by Section 29126 of the Government Code, cancel $144,263 of the appropriation in Account 5210/7885 Contributions to Other Agencies out of a total County contribution appropriation of $212,792 for FY 1978-79 and transfer the amount canceled to the Appropriation for Contingencies, Account 8210/8990. In this way, the June 30, 1978

fund balance may be utilized to reduce the County contribution for the current 1978-79 fiscal year. This will result in a direct, one-time savings to the General Fund which the Board of Supervisors may use for other purposes.

59. That the Department of Health initiate accrual of APCD revenues that are considered fully collectible at the close of each fiscal year.

60. The APCD budget should be adjusted during final changes to reflect APC Board decisions made as the Board of Supervisors that vary from the Proposed Budget. These include salary adjustments, staffing levels, later revenue estimates, and most importantly, the necessary County General Fund contribution needed to balance the District budget. These changes should be identified and proposed by the Health Department, and processed by the County Administrative Office to the Board of Supervisors. Based upon historical budgeting practices, these adjustments will result in a savings to the General Fund.

61. The direct salary costs of the Public Health Laboratory attributable to the air program should be included in General Fund costs charged to the APCD.

62. That the APCD Special District budget, actual expenditures, revenues, and reimbursement transfers to the General Fund be the source of financial data given to air program grant agencies (EPA and ARB) including grant application budgets.

63. That the APCD Special District budget reflect actual expenditure and revenue expectations of the program based upon staffing levels and work goals adopted by the Air Pollution Control Board.

64. That the Accounting Section's financial reports for the APCD properly identify reimbursement revenues from contract counties.

65. That the Health Department consistently report air program encumbrances from year-to-year to accurately reflect financial conditions.

66. That the Health Department accounting staff prepare reports which accurately reflect all financial information on the APCD, and the air quality cost center within the Health Department budget. This information should be shared with

Health Department budget staff and Environmental Health System management on a regular basis to provide them with complete information with which to manage the District.

67. That the Assistant Director of Environmental Health for Environmental Consultation and Protection be assigned responsibility for managing the finances of the APCD and the air quality cost center within the Health Department General Fund budget.

AUDITOR-CONTROLLER COMMENT

The financial information on APCD provided to Environmental Health is incomplete and inaccurate. While we attribute this to the financial management being fragmented, the APCD accounting records must be maintained in a fashion prescribed by the State Controller. In order to do so, it requires the communication of information from Environmental Health with the unit(s) processing and maintaining the records. Since currently no one person has the responsibility at Environmental Health or Fiscal Services Unit, the records are fragmented and limited in value and information.

RECOMMENDATIONS

68. APCD financial records be maintained as prescribed by the State Controller (in the "Uniform System of Accounts in Other (Special) Districts").

69. The utilization of FMIS to provide accurate APCD Revenue and Trial Balance Reports.

70. The monitoring and maintenance of APCD financial records be assigned to the person with the responsibility for managing APCD finances.

Note: There is no apparent conflict between State Controller regulations for APCD and Fresno County Auditor-Controller procedures for the Health Department, Environmental Health.

19. REVENUE RECOVERY EFFECTIVENESS

The Billing and Collections Unit of the Department of Health Business Office is responsible for billing and collecting most of the accounts receivable in the Health Department. This section bills once a month for services rendered to clients for mental health and some public health services. Reimbursement is sought from the State for programs such as the Child Health and Disability Program (CHDP), from insurance companies, private pay (clients), and Medicare. The mental health billing process uses a computerized system that stops billing for a service after two years of non-payment. All other services are billed manually. It costs approximately $2.00 to process a bill and the Department

does not bill for an amount of $2.00 or less. Also, bills are sent until the number of bills sent at $2.00 each approximates the total of the amount due.

All billing records are centrally located at 4441 E. Kings Canyon except Crippled Children's Services (CCS) and Perinatal. CCS has a separate office at the Kings Canyon address and Perinatal is located in the Townhouse building. Both programs do their own billing. However, clients may pay on their accounts at either of these central locations or at the decentralized clinics during regular business hours.

Currently, the Business Office does not utilize follow-up procedures such as letters or phone calls to encourage payment of delinquent accounts. The only exception to this practice is a notice indicating the account is overdue that is automatically printed on the mental health bills by the computer when the account becomes 60 days delinquent, or approximately 90 days after the service is rendered. The County's contract collection agency is not utilized either. Recent turnover of staff, a concern for maintaining the confidentiality of mental health records, and the possible deterrence to using public health services that additional collection efforts might cause, are cited by the Department as reasons for not pursuing collections.

The Business Office prepares a monthly summary of the amounts billed or claimed, and the amounts collected for the month and year-to-date (Exhibit IX). This includes billings or claims for Short-Doyle, Medi-Cal, Medicare, private insurance, State programs such as CHDP and private pay. The Billing and Collections Unit supplies most of the figures for this form, except for the Medi-Cal billing supplied by the Accounting Unit, and Crippled Children's Services and Perinatal which provide their own figures.

The following amounts from the monthly Billing and Collections Report were billed or claimed and collected by the Department during the fiscal years 1977-78 and 1978-79:

	1977-78			July 1978 - Dec. 1978		
	Billed/ Claimed	Collected	Percent Collec.	Billed/ Claimed	Collected	Percent Collec.
Individuals	$1,302,265	$ 244,567	17%	$ 709,703	$ 106,858	15%
Insurance	614,132	208,735	34%	232,654	100,848	43%
Medicare	462,455	296,198	64%	149,127	89,227	60%
Medi-Cal	2,953,454	2,641,669	89%	1,339,572	1,085,727	81%
Short-Doyle	8,520,363	8,510,433	99.8%	2,878,096	2,024,552	70%

The amounts billed or claimed are not the same as the value of the services rendered because a client is billed based on ability to pay, which is frequently less, than the total value of the services. Also, when a client has private insurance, the insurance company is billed the full amount for the client's service since the Billing and Collections Unit does not know how much various insurance policies will pay for specific services. Once the insurance company indicates what it will pay on the account, the client is then billed for the balance of the remaining amount due. Only the original amount billed to the insurance company is indicated on the monthly report. Some accounts also show a credit balance either because of overpayments by the insurance company or the client or because the current record system did not bring old balances forward to the new posting system when it was started in February 1978. Receipt of payments due on the old balances then results in a credit balance. These credit balances currently remain on the client's account unless a client brings it to the Department's attention. Then an adjustment is made.

The Billing and Collections report indicates the Child Health and Disability Program (CHDP) and Perinatal Program have collections far exceeding the amount billed or collected for December 1978. This high total collected for the month distorts the department-wide total revenue collected figure for the month. This is due to the revenue for these programs being received in only one or a few months of a year. Also, for these programs the report shows year-to-date collections exceeding year-to-date amounts claimed or billed. This is because some collections have been received for prior year claims during this month. However, this is not indicated on the report. The Home Health Agency, Crippled Children's Services and "All Others" category of the report also show collections exceeding amounts claimed or billed with no explanation.

The monthly Billing and Collections report does not show current accounts receivable for the various payers. Because there is not an accounts receivable section in the report, it is not possible to readily know the outstanding balances that are owed to the Department and how this amount compares to previous months. This makes monitoring the effectiveness of the billing and collections process very difficult. The only indication of effectiveness on the report comes from the new amounts collected for the month and year-to-date.

The job assignments of personnel in the Billing and Collections Unit are specialized with little or no cross-training carried out on a regular basis. Procedures are not written and personnel must often ask more experienced fellow workers assigned to other functions to resolve problems and answer questions. This is disruptive and results in the compromise of uniformity and continuity in processing billings, particularly when positions turnover or personnel are on vacation.

Also, accounts are sometimes several weeks behind in having payments posted.

Currently, the Department is reviewing its billing and collections procedures, with the intent of clarifying and revising current processes where it appears desirable. The Billing and Collections Unit is also looking into the need for a uniform method of accumulating revenue and accounts receivable information so that it can be put into a more usable form for management review and control purposes. This review of the billing process is being done by staff in the Department's Fiscal and Electronic Data Processing sections.

RECOMMENDATIONS

69. The Department should complete its review of the billing and collection procedures and develop written procedures for staff to follow that simplify billing efforts and result in appropriate recovery of costs.

70. Develop a revised monthly report of billing activities that indicates current accounts receivable balances by source and age.

71. By use of a footnote or in some other manner, indicate on the monthly billing report revenue sources (such as CHDP and the Perinatal Program) that exceed the amount billed for the month or year-to-date and the reasons for the high revenue such as receipts from prior years.

72. Utilize the new Auditor-Controller Collections Unit for delinquent accounts as soon as it is organized and has the capacity for Health Department volumes.

AUDITOR-CONTROLLER COMMENT

We concur with the CAO comments and recommendations. Additionally, we recommend that the monthly report mentioned above include the following data elements for each program:

Summary beginning balance, billings, collections, and summary ending balance.

Prior to implementing the CAO's recommendations, a review of our findings on Internal Control and Financial Information would be appropriate. These findings specifically refer to the Billing and Collections Unit and accounts receivable.

EXHIBIT IX

FRESNO COUNTY DEPARTMENT OF HEALTH

BUSINESS OFFICE REPORT

MONTH OF December 1978

	CURRENT MONTH		YEAR TO DATE	
	Claimed or Billed	Collections	Claimed or Billed	Collections
MEDI-CAL				
Mental Health Services	474,540.58		1,224,980.08	1,011,903.00
Home Health Agency	3,835.01	2,491.15	27,870.99	17,657.33
Family Planning - Fresno		512.07	11,953.05	5,770.08
Decentralized - Pinedale	3,521.47	1,235.02	28,736.01	18,045.69
- Selma	6,797.32	4,308.09	35,956.46	26,303.05
- Firebaugh	1,210.73	399.42	7,444.14	4,974.79
- Five Points	191.68	57.96	2,632.01	1,073.14
- Coalinga				
Totals	490,096.79	9,003.71	1,339,572.74	1,085,727.08
STATE				
Mental Health Services	762,730.68		2,878,096.37	2,024,552.30
Family Planning - Fresno	11,734.81		58,877.40	20,741.62
- Pinedale	552.84		2,652.26	
- Selma	661.84		4,401.06	
- Firebaugh	2,527.95		10,849.98	
- Five Points	261.07		1,653.32	
- Huron	83.87		205.03	
- Coalinga				
C.H.D.P. - Fresno	6,189.70		49,049.91	168,863.69
- Pinedale	2,077.20		5,221.20	8,192.90
- Selma			2,602.30	5,228.60
- Firebaugh				
- Five Points				
- Coalinga				
Perinatal (Incls. Priv. Pay)	8,495.54	282,325.08	8,495.54	437,849.84
Totals	795,315.50	282,325.08	3,022,104.37	2,665,428.95
MEDICARE				
Mental Health Services	14,181.00	1,045.49	93,962.00	29,114.52
Home Health Agency	22,621.33	1,529.50	48,052.98	55,859.02
Family Planning - Fresno				46.85
Decentralized - Pinedale	723.69		3,504.18	2,215.71
- Selma	909.66	18.24	3,607.93	1,990.85
- Firebaugh				
- Five Points				
- Coalinga				
Totals	38,435.68	2,593.23	149,127.09	89,226.95

	CURRENT MONTH		YEAR TO DATE	
	Claimed or Billed	Collections	Claimed or Billed	Collections
INSURANCE				
Mental Health Services	32,397.50	10,441.99	206,057.74	77,918.50
Home Health Agency	34.95	287.52	13,879.62	13,351.33
Family Planning - Fresno			236.59	15.75
Crippled Children Services				4,565.00
Decentralized - Pinedale	669.64	257.59	6,215.53	2,438.14
- Selma		768.98	5,291.32	2,242.39
- Firebaugh	154.90	12.60	659.45	52.94
- Five Points		149.69	313.75	263.79
- Coalinga				
Totals	33,256.99	11,918.37	232,654.00	100,847.84
PRIVATE PAY				
Mental Health Services	112,010.00	11,347.96	641,963.00	58,032.08
Home Health Agency		1,158.45		2,370.87
Family Planning - Fresno	539.35	765.62	12,722.60	9,543.02
Crippled Children Services	3,488.62	4,815.92	17,007.39	15,138.53
Decentralized - Pinedale	3,780.24	1,076.78	13,665.56	8,718.82
- Selma	1,538.30	1,294.44	10,773.04	5,291.39
- Firebaugh	2,394.16	516.19	9,497.96	4,916.39
- Five Points	889.19	1,007.55	4,073.73	2,847.39
- Coalinga				
Totals	124,639.86	21,982.91	709,703.28	106,858.49
SUMMARY				
Mental Health Services	1,395,859.76	22,835.44	5,045,059.19	3,201,520.40
Home Health Agency	26,491.29	5,466.62	89,803.59	89,238.55
Family Planning - Fresno	12,274.16	1,277.69	83,789.64	36,117.32
C.H.D.P. - Fresno	6,189.70		49,049.91	168,863.69
Perinatal	8,495.54	282,325.08	8,495.54	437,849.84
Crippled Children Services	3,488.62	4,815.92	17,007.39	19,703.53
Decentralized - Pinedale	11,325.08	2,569.39	59,994.74	39,611.26
- Selma	9,907.12	6,389.75	62,632.11	41,056.28
- Firebaugh	6,287.74	928.21	28,451.53	9,944.12
- Five Points	1,341.94	1,215.20	8,672.81	4,184.32
- Huron	83.87		205.03	
- Coalinga				
Totals	1,481,744.82	327,823.30	5,453,161.48	4,048,089.31
All others (See attached)	116,501.82	222,857.86	430,065.20	1,338,250.08
Grand Totals	1,598,246.64	550,681.16	5,883,226.68	5,386,339.39

Comments: _____

_____

Prepared by: _____

	CURRENT MONTH		YEAR TO DATE	
	Claimed or Billed	Collections	Claimed or Billed	Collections
LL OTHERS				
Burial Permit		125.00		613.00
Vital Statistics		1,719.00		11,684.00
Milk Inspection	5,725,39	7,582.24	36,597.63	37,007.32
Air Pollution	1,761.00	32,397.28	72,086.78	59,236.39
Abated Auto	6,279.00	14,742.00	29,388.00	26,712.00
Consulation - (U.C.S.F./V.M.C.)	8,840.32	111,371.18	98,285.43	171,495.72
Water Wells	471.38	667.00	2,298.38	1,612.30
Travel Clinic		698.00		5,296.00
Laboratory Tests	5,004.24		35,301.58	23,522.90
Rehabilitation		5,791.90	25,188.45	33,101.59
Firemen Physicals		75.00	439.00	878.80
Personal Services			18,336.80	
Demolition	711.50	955.11	711.50	5,490.29
Motel				34.00
Mobile Home				150.00
Employee Housing		3,135.00		27,564.45
Soft Serve		3,412.50		4,434.37
Medical Report		5.00		67.99
Apollo		2,171.30		13,244.39
N.I.D.A. 3rd Floor & B.A.A.R.T.				63,406.48
CCS Refunds				2,175.78
Miscellaneous		192.48		1,385.83
Rosenberg Foundation				24,000.00
Chronic Disease Control				4,574.50
Immunization			23,085.66	14,527.27
Prior Year Revenue				253.52
314-D				34,100.00
Alcoholism				558,161.00
Clearing 7300		4,656.36		4,671.36
Drug Program - Federal 409				13,495.00
Fresno Comm. Hosp.	399.00		1,036.00	3,728.61
Special Funds				45.80
CETA Programs				1,100.13
CCS Program - Adm. & Medical		32.20		157,317.01
Swimming Pool Inspection				.35
Travel Advance Refund				32.62
Calif. Health Facility Admin.	62,754.00	33,129.31	62,754.00	33,129.31
C.H.D.P. - Admin.	24,555.99		24,555.99	
Federal 314-B				
Home Health Agency - Admin.				
Septage Study				
Firebaugh Clinic Grant				
Coalinga Clinic Grant				
Totals (brought forward)	116,501.82	222,857.86	430,065.20	1,338,250.08

20. USE OF OVERTIME AND EXTRA-HELP

We have reviewed the use of overtime and extra-help personnel by the Department during the period of April, 1978 through January, 1979.

Extra-Help

The bi-weekly computer report titled "Extra-Help Summary Report", shows by employee the number of hours worked and the amount of gross pay. This report does not break down this information by program or administrative unit. As a result, a time-consuming manual tabulation would be necessary in order to review and compare extra-help usage and cost from one pay period to another or between different programs. This is currently not done.

What is readily available and used by the Department as monitoring information is the total hours and cost of extra-help for the pay period covered by each report. This reporting format for extra-help does not provide management with timely and meaningful information to control and regularly review extra-help costs.

The Department does have a Standard Operating Procedure (SOP) (A1500) outlining the procedure for requesting and approving extra-help. This procedure defines extra-help, the allocation of extra-help funds, request procedures and the approval process. It appears reasonably complete and adequate.

The use of extra-help was averaging 2,500 to 3,500 hours per month from April through June. In July, the number of hours was substantially reduced to an average of 1,200 to 1,500 per month because of budget constraints. The extra-help positions consist mostly of clerical help, student social workers, Mental Health Aides, Mental Health Rehabilitation Workers and Work Opportunity Workers. Most of these positions, except the Work Opportunity Workers, are used throughout the Department in several program areas. The Work Opportunity Worker classification is not used to meet workload demands, but is a classification used for certain clients participating in the Mental Health Work Opportunity Program.

During the first six months of fiscal year 1977-78 the Department's extra-help expenditures totaled $167,431. During the same period in fiscal year 1978-79 the cost of extra-help was $47,936. This is a 71% decrease in the cost of extra-help. We also surveyed the Department's use of extra-help, by each position, in January, 1979 and found the Department was using minimal extra-help, and that which was being used was for appropriate purposes.

Overtime

Overtime is reported on the bi-weekly computer report entitled "Payroll Report." It shows the overtime hours worked and total gross pay including overtime pay by employee in each system and special cost center of the Department. These include: Public Health Services, Mental Health Services, Decentralized Services, Environ-Health, Substance Abuse, Program Planning and Development, Financial Services, Administrative Services, Director's Office, community grants, Crippled Children's Services, and CETA. A clerk in the Personnel Section of the Department compiles a bi-weekly overtime report by program which shows the amount of overtime in hours. The cost of the overtime is not shown because it would require an extensive amount of time to compute the cost by program since the overtime cost is not shown separately on the computer printout. As a result, it is not possible for the Department to readily compare overtime costs between programs or pay periods. In June, 1978, the Department did submit a request for data processing services to Computer Services for a time-card historical record file. This program would have allowed the Department to keep more current records of employee vacation and sick leave useage. A side benefit of this program would have been the ability to generate more timely and complete overtime and extra-help reports. The request for the computer program was denied in July, 1978 because it did not appear to be cost-effective.

The amount of overtime (paid and compensation time) incurred by the Department also has generally decreased since July 1, 1978. From April through June, the overtime was averaging 719 hours a pay period. From July through August, it averaged 396 hours a pay period. The Apollo Residency Program and the Inpatient Service generally accrue the largest overtime figures averaging 54 hours and 78 hours a pay period respectively after July 1, 1978. This is also a substantial reduction from before July 1 when it was averaging 155 hours and 161 hours respectively. Since these programs require 24-hour coverage, it is more difficult to reduce overtime because of the need for some personnel to cover more than five shifts per week due to vacancies and illness. During the period of July 1, 1977 through December 1977, the Department's overtime cost totaled $20,832. During the same period in fiscal year 1978-79 the cost of overtime was $13,115. This is a 37% decrease in the cost of overtime.

We also reviewed the reasons, by each position, for use of overtime for January, 1979 and found the Department was using a minimal amount of overtime and only when it was necessary. The overtime was incurred by several classifications such as Typist Clerk, Mental Health Aide, Psychiatric Social Worker, Mental Health Nurse and Sanitarian. These positions are used in several program areas throughout

the Department.

Accurate, complete, and timely overtime cost information, preferably by individual program, would result in better control and accountability of this expenditure. SOP A635.2 and A1832 briefly indicate that overtime shall be paid only for those hours in excess of approved work schedules and must be authorized. Section 800 of the Salary Resolution also defines overtime use and compensation. While the SOP is very brief, it appears sufficient since the Salary Resolution provides adequate policy direction on the use of overtime.

RECOMMENDATION

75. The Department should investigate the cost and feasibility of developing more useable and complete overtime and extra-help reports that show the usage and cost of these resources by program. This should include exploring the possibility of revising current computer and manually generated reports.

21. AUDITOR-CONTROLLER FINDINGS

FINANCIAL INFORMATION

The Auditor-Controller's involvement in the Health Department audit was in conjunction with the proposed implementation of a Countywide automated cost accounting system. The Systems and Internal Audit Divisions were assigned to do a systems study and internal control review of Health in coordination with the County Administrative Office management team. Our study began with a financial review of the Fiscal Services Section. This Section consists of an Accounting Unit and Billings and Collections Unit.

During our review, we noted that the personnel in Fiscal Services generally lack a comprehensive understanding of FMIS and an overall working knowledge of Health Department operations. Specific job knowledge appears to be adequate; however, we also noted fragmented responsibilities, and in instances a lack of overall operational coordination. The result has been inaccurate and/or incomplete accounting records and reports, and possibly, a duplication of accounting information gathering and reporting efforts. Considering this, we believe improvement of the current systems is of more immediate importance than the implementation of a cost accounting system.

RECOMMENDATIONS

76. Accounting staff become fully knowledgeable in

FMIS and its reports.

77. Clerical and professional staff be oriented and coordinated with the sources of financial information in Health Department.

78. The departmental accounting functions and procedures be reviewed for immediate improvement.

Accounting Unit

In the Accounting Unit, we directed our efforts to a review of the policies, procedures, and the financial data utilized in the current system to generate accounting reports and claims. The informational reports of FMIS are distributed to cost centers to monitor their financial status. In reviewing the internal report procedures, we noted the following deficiencies:

- FMIS reports are not reconciled with original documents or distributed on a timely basis.

- Amounts representing salaries and benefits are from labor distribution, but the labor distribution is not reconciled with FMIS or actual payroll.

- Trust fund and bank account reconciliations were not complete.

- Workpapers for reimbursement claims are not properly indexed, cross-referenced or fully documented.

RECOMMENDATIONS

79. All financial information and source documents be reconciled with FMIS reports.

80. All financial reports be distributed on a timely basis.

81. Reconcile Trust Funds and Bank Accounts with source documents.

82. All workpapers for claims and/or grants be complete and organized for rapid reference and be readily understandable.

Billings and Collections Unit

In the Billings and Collections Unit, we limited our review of accounts receivable to those maintained manually. We did not review the automated mental health billing system.

In addition, we reviewed the cash receipts and deposit procedures and noted the following:

- Since there is no direct professional supervision, there is a lack of consistency in the interpretation of accounting policies and procedures.

- The manual accounts receivable system is inadequate and does not provide informative reports.

- Accounts receivable records are not current; therefore, the staff is unable to do follow-up collections on accounts.

RECOMMENDATIONS

83. A full-time Accountant be responsible for management of the day-to-day operations.

84. The manually maintained accounts receivable systems be revised to enhance collections and reporting efforts.

Action to Date - Billing and Collections Unit

The Health Department has initiated an internal review of the Billings and Collections Unit. The review team will document current procedures and analyze problem areas. From the information gained in this review, functions, procedures and systems will be revised to provide a more efficient operation and will be utilized to orient new employees.

INTERNAL CONTROL

Internal control consists of all measures employed by an entity for the purposes of 1) safeguarding its resources against waste, fraud, and inefficiency, 2) providing assurance to management of the dependability of accounting data, and 3) encouraging and measuring compliance with policy.

While the elements of a system of internal control are difficult to list, there are certain factors, however, that must be present. Among these are the following:

- An organization which establishes clear lines of authority and responsibility.

- Adequate accounting procedures and records.

- Personnel with the ability and experience required to perform satisfactorily the responsibilities assigned to them.

Billings and Collections Unit

In reviewing the controls of Billings and Collections Unit, we found the following weaknesses:

- Payments are not always immediately receipted or deposited promptly and intact due to 1) a cumbersome receipting system, and 2) lack of information as to revenue distribution.

- Cash handling functions are not adequately separated i.e., receipting, depositing, reconciling, posting to the accounts receivable subsidiary records.

- Duties and responsibilities of employees are not clearly defined.

- Subsidiary accounts receivable are not reconciled to control accounts.

- Adjustments to accounts are not always documented or approved by supervisory personnel.

- The unit lacks the direct accounting supervision to establish proper controls, to advise the clerical staff, to revise systems and procedures, and to complete other duties as necessary.

RECOMMENDATIONS

85. Duties and procedures be clearly defined and separated so that no one individual has complete control over a cash transaction.

86. The Billings and Collections Unit be directly supervised by an Accountant with the expertise to correct any identified weaknesses in systems and controls.

87. Reconciliations of cash and receivable transactions be performed regularly.

88. Adequate documentation and approval be required for any adjustments to accounts.

COUNTY ADMINISTRATIVE OFFICE COMMENTS

In view of the condition of the accounts as maintained by the Financial Services System of the Health Department, the Auditor-Controller's staff was unable to conduct such tests of the accounts as is appropriate to conclude a financial audit. We suggest the Auditor-Controller resume his audit later this year to determine progress in correcting the condition of accounts and processes, and to conclude his audit.

SECTION VI. PROGRAM MANAGEMENT

22. MENTAL HEALTH PATIENT ADVOCACY

Mental health patient advocacy is the supportive representation of patients; interests and the protection of patients' rights guaranteed by State and Federal laws. Section 863.1 (a), Article 6, Title 9, of the California Administrative Code requires that "...each county mental health director shall assign a Patients' Advocate to handle complaints of mentally disabled patients and residents regarding the abuse, unreasonable denial, or punitive withholding of a right guaranteed under Section 861 of this article...".

The article applies to voluntary and involuntary patients residing in both public and private acute psychiatric facilities, skilled nursing facilities, intermediate care facilities, and residential care facilities. The rights must be posted in all the aforementioned facilities and copies of these rights provided to each individual upon admission to the facility.

The Health Department assigned a Psychiatric Social Work Supervisor to perform the patient advocate function at about 30% of fulltime. Annual net County cost for this function at 30% of fulltime is about $850 because 90% of the cost is offset through State Short-Doyle program revenue. The remainder of the incumbent's time is spent performing miscellaneous projects for the Associate Director for Mental Health Services (35%), legislative and program review (15%), committee and task force representation (5%) and other assignments (about 15%). The patient advocate function is recognized by the Department as the most important responsibility of the Psychiatric Social Work Supervisor.

There are three acute psychiatric inpatient facilities, 13 intermediate and skilled nursing facilities, and 31 licensed residential care facilities in Fresno County which by regulation are subject to application of Article 6 to ensure that patients are properly notified of their rights. The patient advocate must investigate and attempt to resolve all complaints received from patients at the above facilities. Estimated annual number of complaints for 1978-79 is 360.

Patient advocacy requires liaison with other agencies such as the State Department of Health Licensing District Office (responsible for licensing health care facilities), the

Public Defender, interested community organizations, County Counsel, District Attorney, the State Department of Mental Health, and the facilities and institutions which fall under patients' rights regulations. Other activities not mandated but desirable to meet the intent of the regulations include, 1) training of personnel at mental health care facilities about patient rights, and 2) distribution of patients' rights information through speaking engagements to concerned individuals and groups and the media.

Currently, the requirements to process and resolve patient complaints and provide quarterly reports are met. There are also some other activities going on in patient advocacy. For example, the residential care facilities operators have received an orientation and were provided with copies of the patient rights regulations, signs and patient rights handbooks. Initially, when the data became available, all were invited to a training session. The Advocare Program also supplies handbooks to the facility operators on request and has provided back-up to the patient advocate services when necessary. They document contacts and forward the information to the patient advocate for follow up or filing. In the past two and one-half years, eight of the forty-six facilities have been visited by the advocate in reaction to individual patient complaints.

The regulations do not require that facilities be visited by the patient advocate on a regular basis to ensure compliance with patients' rights mandates, but State patients' rights staff indicate that a semi-annual period is desirable. Advocare staff goes into all of the facilities on a quarterly or more frequent basis.

When the mandate for mental health patient advocacy was established (1975), the State did not create additional offsetting funds under the Short-Doyle program. Counties have financed this function mainly within existing Short-Doyle allocations.

Before passage of Proposition 13, the State Department of Health proposed $1.5 million for 1978-79 to subsidize 90% of the funding for county mental health patient advocacy. Fresno County's allocation was tentatively $35,000 which represented 1.2 full-year-equivalent (FYE) positions and included salary benefits, departmental and A-87 overhead, plus travel expenses. It is apparent, from the State's tentative allocation amount that the current time spent in advocacy falls short of State expectations by almost one FYE position.

It is also apparent that the State recognized this mandate would require additional State funding or a reduction in the distribution of Short-Doyle funds to patient care in

order to finance it. The passage of Proposition 13 resulted in the cancellation of the State proposal for additional funding. According to staff of the State Department of Mental Health Patients' Rights Office, the prospects look dim for a similar proposal in 1979-80.

The net County cost to provide one FYE position would be approximately $2,834 (at the 1978-79 salary including overhead) after Short-Doyle offset revenue. This is an increase of $1,983 over current net County costs to provide the advocacy function at 0.3 FYE.

ALTERNATIVE WAYS TO PROVIDE THE ADVOCATE FUNCTION

Recommendation 28 made by the Joint Advisory Committee for review of the Mental Health Inpatient Unit and Valley Medical Center in their November 21, 1977 report to the Board of Supervisors was that the patient advocate should not be a Fresno County Department of Health employee but should report to the Board of Supervisors via the County Administrative Office or Mental Health Advisory Board. The following are presented as alternative ways to provide the patient advocate function.

County-Employed Advocate in County Administrative Office Versus Department of Health

Of the 58 counties in California, 53 counties have county-employed mental health patient advocates; three counties (Alpine, Nevada, Placer) have outside volunteer mental health patient advocates; and two counties (San Diego and San Francisco) have contracts with outside agencies to provide mental health patient advocacy. Of the 53 counties with advocates on the county payroll, none are in their county administrative office organizations. According to staff in the State Department of Mental Health, all of the county-employed advocates are employed by their county mental health or health departments. At the State level, the State's Patients' Rights Specialists who work with the State mental hospitals and county advocates are within the State Department of Mental Health.

The data suggests that the majority of counties prefer retaining the mental health advocate function within, or closely aligned to, the organizations responsible for provision of services. The reasons for this apparently are: 1) county health departments have the professional expertise to provide the service, 2) because of this expertise, cooperation between the advocate and other professional staff to resolve patient complaints may be greater than if the advocate were a non-clinician such as an attorney, 3) the advocate can be kept abreast of pertinent legislation and regulatory developments concerning mental health practices affecting patient's rights, and 4) resolution

of patient complaints is recognized as an integral part of the Department's responsibilities to meet State and Federal laws governing mental health service delivery.

County-Employed Advocate Reporting to Mental Health Advisory Board

The Mental Health Advisory Board (MHAB) is provided by State law under Section 5604 of the Welfare and Institutions Code. Its duties entail review and evaluation of the community mental health needs, approval of the procedures in the County's Short-Doyle planning process to ensure citizen and professional involvement, review of the Short-Doyle Plan and advice and reports to the Board of Supervisors and the Local Director of Mental Health Services regarding community mental health programs, services, and facilities (Welfare and Institutions Code, Section 5605). The MHAB may make recommendations to the Board regarding the assignment of a local director of mental health services.

The MHAB's function by law is limited to that of an advisory body, whereas the mental health patient advocate is charged to ensure compliance with mental health patients' rights. The local Director of Mental Health Services is ultimately responsible for administering the regulations concerning patient rights and patient advocacy. It would, therefore, seem impractical to have a patient advocate report to a Board that does not have the legal regulatory responsibility to administer the patient advocacy program.

There is also some question whether a committee could effectively supervise a field position if the committee itself meets only on a part-time basis.

Contract Advocacy with Outside Agency

Counties which have outside contract advocacy are San Diego and San Francisco. We talked with the contract advocate in San Diego to discuss the possible advantages and disadvantages of contracting out the advocate function.

Accessibility to patient case file information when investigating complaints is a possible disadvantage of contracting the function to an outside agency. Section 5328 of the Welfare and Institutions Code generally prohibits the release of patient information to others outside the professional service organization without written permission of the patient or the patient's guardian.

Independence to make recommendations without fear of County departmental influence is felt to be an advantage

of contracting the advocate function to an outside agency. However, the County employee advocate position could be placed in the Health Department organization in such a way as to minimize this risk, and there is of course no more potential conflict for the County in dealing with private institutions than a contractor. The MHAB can also serve as an investigator of patient complaints in County facilities to see that the advocate is being effective.

Costs are not a major factor to consider in contracting out the advocate function since all counties contacted reported that costs were 90% reimbursed under Short-Doyle program funding. San Diego County reported that it was less expensive for them to contract the advocate function because of their county overhead costs. San Francisco County indicated that because of pressure from mental health interest organizations concerning the potential for conflict of interest, they decided to contract for advocacy.

A problem of contracting advocacy is finding a knowledgeable contractor to represent individual patient rights. Since there are only two contract advocates in the State, there are few available potential contractors with experience in this field.

In addition to the problem of few experienced and qualified contractors, the County might have insufficient control as a purchaser of services to ensure the contract advocate devotes energies strictly to individual patient rights rather than pursuing other issues. For example, a contract advocate could conceivably have personal opinions about such things as treatment philosophy and methods that are in conflict with Department of Health policy or the policy of the private institutions with which they would deal.

While County policies should be and are exposed to scrutiny through the MHAB, the contract advocate might use his official status as a platform for promoting views on matters outside his contract responsibilities. In this situation a conflict of interest could arise that might require contract cancellation, with consequent disruption to the advocate function. This risk is heightened because the shortage of experienced contractors would tend to attract bidders with vested interests in mental health care.

It is very difficult to measure the effectiveness of patient advocacy, or furthermore, to determine what the appropriate level of resources to be invested in the function should be. The County, therefore, through the Short-Doyle planning process must decide what level of

activity of patient advocacy is minimally acceptable to meet its obligations and responsibilities, and staff the function at least to that level.

The Psychiatric Social Work Supervisor class may not appropriately reflect the single most important responsibility of the advocate position, nor does the position have any supervisory responsibilities.

RECOMMENDATIONS

89. That the patient advocate function continue to be performed by the Department of Health.

90. That the Psychiatric Social Work Supervisor position handling this assignment be deleted and a Patient Advocate position be added to appropriately reflect the position's most important responsibility.

91. That the Patient Advocate position report directly to the Associate Director for Mental Health if performing these duties as only part of his total responsibilities, or to the Director of Health if a full-time advocate. This will permit the greatest protection from interest conflicts at the highest level where unified supervision can be given.

23. CLASSIFICATION STRUCTURE OF MENTAL HEALTH PROGRAM

The Department presently utilizes several job classifications to staff the various mental health programs. These include Psychiatric Social Work Supervisor, Psychologist, Psychiatric Social Worker, Supervising Mental Health Nurse, Mental Health Nurse, Administrative Services Assistant, Mental Health Rehabilitation Worker, Recreational Therapist, Licensed Vocational Nurse, Occupational Therapist, Psychiatric Technician, and Mental Health Aide. Most of these classifications have been in existence for several years and are patterned after similar job titles used in other counties and outlined in the California Administrative Code, Title 9.

Community mental health programs are based on the premise that clients will receive the maximum benefit from treatment in their own community where family and social ties exist. Also, it is felt that appropriate

treatment can be most effectively and economically provided by a team of mental health personnel with varying types of training and skills necessary to deal with various needs of clients (see finding 8, Health Care Delivery Teams).

We reviewed the qualifications and job duties of personnel in the various programs through employee interviews and review of classification questionnaires prepared for the Personnel Management Division. As a result of our review, we found three instances where it appears positions may not be utilized to the extent of their professional qualifications. In the Rehabilitation Program, a Psychiatric Social Work Supervisor has been assigned routine staff work characteristic of the duties of a Psychiatric Social Worker. In Crisis Services, a Psychiatric Social Work Supervisor is currently assigned responsibilities commensurate with a Psychiatric Social Worker II since the position does not have any overall responsibility for the supervision and coordination of one or more programs. In the third instance, a Psychiatric Social Work Supervisor reports to the Mental Health Program Chief. This Psychiatric Social Worker does not supervise a program or any other personnel, but acts solely in a staff capacity in gathering information, writing reports, reviewing legislation and serving on various committees, and serving as a patient advocate.

We question whether these instances are a cost effective use of higher salaried classifications. Use of higher classifications in this manner also may have a negative effect on department morale.

Most clients entering the mental health system are initially interviewed by a staff person in the Crisis Program. The crisis worker, which in practice could be any of the above classifications except Administrative Services Assistant, Occupational Therapist, or Recreational Therapist, tentatively diagnoses the client's problem and recommends a treatment plan outlining goals and a timetable for achieving those goals. Then the treatment plan is reviewed by a psychiatrist who may or may not personally see and evaluate the client to validate the diagnosis and plan, depending upon the specific circumstances of the case.

In Crisis Services, the distinction between duties performed by Mental Health Aides, Psychiatric Technicians, Mental Health Rehabilitation Workers, Psychiatric Social Workers, and Mental Health Nurses is frequently not clear. Some Mental Health Aides, Psychiatric Technicians, and Mental Health Rehabilitation Workers (approximately 11 positions) conduct individual, family and group therapy sessions which are prescribed duties

of a Psychologist, Psychiatric Social Worker or Mental Health Nurse. Despite different job descriptions and educational levels, these employees appear to be performing duties that are traditionally prescribed for the higher classifications because of the level of educational preparation required to be clinically effective.

The Mental Health Aides and Psychiatric Technicians were not intended to perform in as independent manner as the higher classifications. Counseling and consulting with patients and families concerning treatment recommendations, progress, discharges, and follow-up is an example of Psychiatric Social Worker or Mental Health Nurse duties. The Mental Health Aide and Psychiatric Technician classifications were intended to assist in carrying out various treatment programs under the supervision of the higher classifications. Typical duties of a Mental Health Aide would include observing and reporting patient behavior, transporting patients, preparation of materials for various activities and participative and instructional interaction with patients. Psychiatric Technicians perform duties such as observing and reporting patient behavior, assisting nurses and doctors when directed, and ensuring patient participation in group treatment programs. The Mental Health Rehabilitation Worker was intended to assist the professional treatment team by providing patients with social casework counseling and referral services, particularly in areas of vocational training, financial assistance, employment, housing and transportation.

In contrast to Crisis Services, Youth Services utilizes only professional classifications of Psychiatrist, Psychologist, Psychiatric Social Worker and Mental Health Nurse for various types of diagnosis, developing treatment plans, therapy sessions, evaluation and discharge.

This varied use of subprofessional classifications has occurred for several years. Originally, as the various Health Department programs were started, existing positions from other services in various classifications were utilized as available. Some positions were over-utilized for their classification initially, and in other cases, the positions gradually assumed more responsibilities characteristic of higher classifications. We question whether competent mental health services are being provided all clients by these mental health programs which utilize classifications of personnel for purposes more rigorous than their professional training can support.

In interviewing professional staff in these programs, we have generally received favorable comments that most subprofessionals have become proficient at these more

sophisticated duties. The Health Department's mental health employees do appear to be dedicated to providing quality mental health care to clients. The staff is able to effectively cope with a wide range of client problems under what are frequently very difficult circumstances. Most client treatment is on a voluntary basis and a rapport and feeling of trust must be developed between staff and clients before meaningful treatment can take place. Most personnel displayed the positive attitude and understanding necessary for successful treatment. The staff has also had to adapt new programs enacted in the last several years, such as the Apollo residential program, that have put additional demands on them to be innovative and attempt to make programs work with limited physical resources such as minimal building space.

RECOMMENDATIONS

92. The Personnel Management Division, in cooperation with the Health Department, should complete a review of the classifications in the Mental Health System of the Department to bring classifications into line with job duties where positions are underutilized.

93. The Department should design a proposed optimal job classification and staffing structure for each of the mental health programs for the efficient and effective delivery of services.

94. Subject to classification review by the Personnel Management Division, redirect current positions into the optimum design classifications for these programs as attrition, transfers and financing permits.

24. PSYCHIATRIC RESIDENCY PROGRAM

The Health Department offers a fully accredited three and four year Psychiatric Residency Program in affiliation with the Department of Psychiatry, University of California at San Francisco School of Medicine. Individuals are required to spend three or four years in the program depending on prior training for board eligibility. Currently, there are six residents in the program. The 1978-79 budget for the program totaled $503,096.

The program is supported by funds from the State Short-Doyle program (64%); the County (7%); the University of California at San Francisco (12%) which is for the full-time teaching position of one psychiatrist, one part-time psychologist, and one half-time stenographer II; reimbursement for service to Valley Medical Center (11%) which is for the teaching services of the residency program equivalent to one full-time psychiatrist position; and revenue from clients and third party payers for services rendered by residents (6%).

The intent of the County's participation in the residency program is to encourage psychiatrists to practice within the Central Valley of California either in the public or private sectors. The program also seeks to expose psychiatrists to the needs of populations traditionally underserved by psychiatrists such as those living in rural areas, minority groups and criminal offenders. A third benefit is the direct treatment time that the Health Department's mental health programs receive from residents.

Since the program was placed in operation in 1973, eight residents have graduated. Four are currently practicing in California. These include one in private practice in Fresno, one in Long Beach, and one working half-time in private practice in Stockton. One graduate is working in a Los Angeles hospital which serves a large minority area and the psychiatrist in Stockton works half-time in a community mental health center. One of the four graduates serving out of state is receiving additional training and one is serving in the Army. Both are considering returning to Fresno when they eventually locate to practice psychiatry.

Psychiatrists are needed in the County Health Department's Mental Health System, but so far none of the residency program graduates have practiced in the Mental Health System after they graduate. Several have expressed an interest in practicing with the Department and approximately two years ago one graduate sought to practice in the Department but there were no contract slots available at the time.

The degree of coverage that the residents provide in County mental health programs is determined primarily by the Medical Education Director who currently reports to the Director of Health. During fiscal year 1977-78, 847 hours of psychiatric residency time was spent in patient care in Crisis and Adult Day Treatment. Youth Outpatient received 49 hours of service and Inpatient received an undetermined amount of time since exact records of residents' time spent at Inpatient are not kept. The cost of a resident's salary averages less

than a half of that of a psychiatrist's compensation ($11.53 per hour versus $23.74). Currently, there is a shortage of psychiatrists in the Department. This shortage is the most acute medical specialty shortage in the San Joaquin Valley.

The total cost of the program for fiscal year 1977-78 for seven residents was $437,421. This included $143,890 for faculty; $106,011 for stipends to residents; $27,634 for clerical help; $92,494 for training provided by primary therapist; $48,984 for Department and general County overhead; and $18,408 for fixed assets, services and supplies. The faculty also is involved in the training of primary care physicians, other medical specialties, medical students and offers some direct patient care services. The faculty also provides Continuing Medical Education (CME) to other department physicians and to the physicians in the community.

We deducted revenue generated by the program for psychiatric services rendered to reflect the actual training cost of $344,412, or $49,202 per resident for the one year. This cost included stipends of $14,560 to $21,350 per resident depending on their year of residency. The State's share of this cost was $251,350; the University of California $65,134; and the County's share was $27,928. The State and County funds do not have to be spent on this program, but could be spent directly for additional psychiatrist time and in direct service mental health programs. However, if the residency should cease existence, there is a strong possibility that the State would withdraw the funds currently used in the program. In addition, the ability to recruit qualified psychiatrists would be more difficult without the presence of the residency program. However, if the program was not operative the Department and general County overhead ($48,984) and the cost of training provided by primary therapists ($92,494) would still be incurred. This is true since the overhead would not be appreciably affected by this program and the primary therapist would still be providing therapy to clients.

Though residents are utilized in the Department's mental health programs, their scheduling could be better coordinated to help meet workload of the services to which they are assigned. By having the Residency Program under the Associate Director of Mental Health as recommended in finding 1, Organization, resident coverage of mental health programs could be better coordinated with their residency schedule.

RECOMMENDATIONS

95. The Residency Program should continue to actively attempt to attract residency candidates who show or have shown an interest in community mental health programs and would most likely remain in the local area to practice psychiatry.

96. Consistent with appropriate residency training, the Department should use available patient care time of residents to effectively assist in the Department's mental health services.

97. That the Department of Health keep accurate records of the time psychiatric residents spend in patient care activities in each of the County's mental health programs. This will permit a better evaluation of the secondary benefits of the program.

AUDITOR-CONTROLLER COMMENT

The University of California at San Francisco issues purchase orders to the Department of Health for professional and secretarial services in the Residency Program. The cost of these services are claimed pursuant to a formal agreement between the University of California and Valley Medical Center.

25. RESIDENTIAL TREATMENT PROGRAM FOR YOUTH

For at least 10 years the Department has recognized the need for a youth residential treatment program and included proposals in the Department's five-year Short-Doyle plans. However, these proposals have not yet received any State funding. In 1973-74, the Department had budgeted a sum of money in County revenue sharing funds for a residential treatment building. The State did not support this with the addition of program funds. In January, 1976, approximately 30 representatives from the Juvenile Justice System and the Department of Health met with the State Department of Health to discuss the ramifications of the Michael E. court decision. A major interest of this group was the apparent need for extended 24-hour treatment and care of certain juvenile offenders and non-offenders with serious mental health problems.

The Michael E. decision had placed severe restrictions on the use of State hospital programs for these youth but did not indicate how local residential treatment programs were to be utilized to meet the needs of these clients. At any one time in Fresno County there are an estimated 50 youths who exhibit such severe behavioral and emotional problems they are unable to live harmoniously with their families, in foster care or existing group homes. Such problems exhibited by these youths include chronic running away from home, depression, severe anxiety, social withdrawal or psychosis. These same youths are unable to maintain positive relationships with peers or non-family adults and are often unable to attend regular school. Such problems may be derived in part from inadequate parenting and others may be derived from lack of other support systems such as special education or mental health services.

The intent of the County Health Department in participating in efforts to organize a mental health residential treatment program was to satisfy an apparent need of a select group of youths for whom appropriate treatment such as a non-hospital 24-hour residential treatment center would provide.

The group formed an interagency task force to look into the needs for and the possibilities of developing local programs for 24-hour residential care for youth less than 18 years old. The task force was composed of representatives from the Probation Department, Department of Health, and Juvenile Justice Commission. They were directed also to look at existing services and possible funding sources for residential care.

The task force concluded in April, 1976, that a local residential treatment facility for youth was needed. Also, a study by the public policy research firm of Arthur Bolton Associates conducted for the State Department of Health in 1976 indicated a need for a local facility in Fresno to serve the needs of Fresno County. Currently, according to the Bolton study, an estimated 100 mentally disordered juveniles are placed in treatment facilities outside of Fresno County. This tends to isolate the youths from families, Probation staff, and the County Health Department staff, and makes re-entry into the community more difficult.

No action resulted from the efforts of the first task force. However, a second task force began meeting in January, 1978, to review possible funding sources and locations for the facility, and design possibilities for the physical plant. The committee included members from the Health and Probation Departments, Fresno Unified School District, and the Fresno County Department of Education. This committee met until June, 1978, when the members voted to discontinue meetings because of budget uncertainties caused by Proposition 13. The Service Chief

for the Youth Service Day Treatment Program during this period of time was instrumental in representing the Health Department on the committee as well as the Department's proposal outlined in the 1978-79 County Plan document.

Your Board was advised of these treatment resource needs during briefings by the Department of Health on the Mental Health Inpatient Ward in January and March, 1978. At the March meeting you supported continued Department of Health efforts to secure funding for an Adolescent Inpatient Unit.

Reports briefly outlining the Department's program proposals have been submitted to the State Department of Health on many separate occasions; the first being the 1969-70 Short-Doyle plan and continuing until the most recent program submitted on January 9, 1979. The basic proposals developed in June and August of 1978 and January, 1979, were submitted under the signature of an Administrative Services Assistant II, which was a department-approved practice, after the State Department of Health notified the County of the possibility of additional Short-Doyle funds for such a program. This funding has not yet materialized. While the Department has reviewed information on this subject, researched the need for this type of facility and been in contact with the State Department of Health about this need, a complete proposal was not submitted until 1979. All of these efforts could have been better coordinated and directed by top management to achieve maximum results.

Presently, there is legislation (the Bates Bill) pending in Sacramento that could make up to $3 million available to selected counties (including Fresno) which could be used for a structured residential treatment facility. A formal proposal has now been drafted and was submitted in January, 1979 to the State Department of Health under the signature of an Administrative Services Assistant II. It included letters of endorsement from affected agency heads throughout the County except the Director of Health, Acting Local Director of Mental Health, and Acting Health Officer. The Department did not seek or obtain a new resolution of support from your Board which, while not mandatory at the time, would have added strength to the proposal. However, since the State Department of Health Services first met with the Department on December 15, 1978 to advise the County of the availability of those funds, the Department did not feel it would have time to obtain a Board of Supervisors resolution and still submit the proposal by the January 10, 1979 deadline. Sources of funding for operating such a facility include Medi-Cal, Child Welfare, Probation, Social Security, and Short-Doyle funds (Exhibit X).

RECOMMENDATIONS

98. Since the Department gave this program a high priority, it should continue to aggressively pursue funding sources for this residential treatment program.

99. That the Department's efforts to secure this and subsequent program proposal funding include timely submission of complete project proposals to funding agencies and that they leave the Department under the Director's signature. These major submissions should be coordinated with expressions of support from your Board, affected community groups and advisory bodies, and community leaders.

EXHIBIT X

24-HOUR RESIDENTIAL TREATMENT CENTER

SOURCES OF FUNDING

The Residential Treatment Center proposal is designed at present to accommodate 24 youths at a time for a maximum 8,760 patient days a year. The estimated annual cost of the service is $859,192 which translates to a daily cost of $98.00 per unit or monthly rate of $2,940 per unit.

Funding sources other than Short-Doyle and County match are estimated in the following table:

Source of Revenue	
Medi-Cal	$120,960
Child Welfare	191,488
Probation	241,920
S.S.I	26,568
TOTAL REVENUE	$408,936

The balance of funding to be covered by Short-Doyle and County matching funds is as follows:

Total Annual Cost	$859,192
Less Outside Contributions	- 408,936
Short Doyle and County match	$450,256

26. EMERGENCY MEDICAL SERVICES

Origin of County Involvement

Under statutes of 1968, the Fresno County Board of Supervisors has been responsible for appointing members to the County's Emergency Medical Care Committee (EMCC) which is established under Health and Safety Code Sections 1750 and 1752. The EMCC is responsible for the review of local first aid practices, emergency medical care (EMC) and ambulance services. The EMCC is supposed to make annual reports to the State Advisory Health Council, State Department of Health Services and the areawide comprehensive health planning agency for its area. This report is supposed to be submitted to the Board of Supervisors for their review.

Health and Safety Code Section 1760 was added by Statutes of 1969 and broadened the scope of County and State emergency services responsibilities. Section 1760 describes the services and functions of an emergency medical services program that the State Department of Health Services is responsible for maintaining in cooperation with local agencies. These responsibilities include the collection of data, evaluation of EMS, establishment of recommended standards, provision of plans for emergency medical assistance from nearby communities and other resources throughout the State, providing consultation services to the EMCC of each county; and, as provided in amendments of 1973, the establishment of emergency medical training and educational standards for ambulance personnel.

Distribution of County Responsibilities for EMS

In July 1975, the Board of Supervisors passed a resolution designating responsibilities for various aspects of the EMS system to the County Administrative Office (CAO), Health Department, Comprehensive Health Planning were assigned Association (CHPA), and the EMCC. Planning for the EMS system for the County was assigned to the CHPA (now Health Systems Agency for Fresno County and adjoining counties and Health Systems Council (HSC) for Fresno County). The tasks of advising, monitoring, and evaluating the EMS system for the County were assigned to the EMCC. The CAO was assigned management and coordination duties and the Health Department was assigned responsibility for administration of the system. The CAO duties were not clarified, but the administrative duties of the Health Department were more explicit. They included implementation and operation of the County portion of the public-private EMS system, carrying out standards indicating how and who will deliver EMS, developing financial methods to operate the EMS system, and establishing procedures to collect, analyze, and distribute information.

Developments Since 1975

Since 1975, progress in the development of an EMS system has been minimal. EMCC has held monthly meetings until June 1978, when meetings were suspended. The CAO is in the process of re-activating this committee and scheduled a meeting in March, 1979 to determine its future course of action.

Comprehensive Health Planning, which was funded jointly by Fresno County, adjoining counties and the Federal government as the health services planning agency for the Central San Joaquin Valley, did form a task force to develop an EMS plan. However, the task force never produced a plan, primarily because the CHPA was terminated by the Federal government in 1976. The Health Systems Agency (HSA) was then formed as the Valley's health planning agency. This new agency, also funded by Fresno County and adjoining counties and the Federal government, is responsible for developing a master plan for the delivery of health services in Fresno County and adjoining counties. This plan is to include an emergency medical services element. This element has been drafted recently, but has not yet been reviewed by the EMCC, Health Department or CAO.

The Health Department staff has attended some of the CHPA and EMCC meetings during the past four years. However, the Health Department's main involvement in EMS has been to approve a curriculum and training program for paramedics and certified applicants and establish criteria to maintain certification of qualifications of the County's emergency paramedics. The paramedic program is the most significant recent addition to emergency medical services in Fresno County.

The Administrative Office's role in EMS has also been limited primarily to attending some meetings of HSA and EMCC and assisting with the paramedic program. It also has been active in securing and implementing a grant for emergency medical communications which has recently been awarded to the County.

Appraisal of the Situation

The general lack of activity in developing an EMS system is due to several factors. The State's guidance and participation in developing the EMS has not been successful in the San Joaquin Valley. The County's responsibility has been fragmentary rather than comprehensive so that local leadership has not emerged to fill the void.

Since the Board of Supervisors action in 1975 distributing local EMS responsibilities, planning has been slowed by the

changes in planning agencies. Organizational and staff changes have made it difficult for the new agency to carry out its planning function. Also, since an EMS plan was not mandated by a particular date, EMS development has taken a lower priority than other projects in the HSA, Health Department and County Administrative Office.

The EMCC was designed to evaluate the EMS and serve as a forum for community input to the Board of Supervisors, the HSA, and the State Department of Health Services. We are unaware of the reasons for suspension of EMCC activities but they may be related to the above described leadership problems, and a lack of planning and data with which to evaluate the County EMS.

The Health Department recently (March, 1979) formed a multi-agency task force to evaluate the current status of EMS and plan a proposed future course of action for the County and other agencies in administering the system. The agencies and County departments on the task force include five hospitals, three fire departments, four ambulance companies, two police agencies, the EMC Committee, Fresno/Madera Medical Society, Public Administrator/ Guardian/Coroner's Office, Health Department and County Administrative Office. The formation of a task force by the Department consisting of the many local agencies that provide emergency medical services is a positive step in the development of an EMS system.

Consolidation of County Responsibility

The current distribution of responsibilities between the CAO and the Health Department is probably no longer functional. At one time, CAO involvement was thought to be necessary to facilitate coordination between VMC and the Health Department. Under present conditions, this no longer appears to be necessary. What appears to be a health administration responsibility perhaps can be more effectively assigned to a single department with the access to information and expertise necessary to carry it out. Divided responsibilities between Valley Medical Center, the Health Department, and CAO have met with limited success in the paramedic program and EMS communications grant, and it would appear appropriate to consolidate these responsibilities to facilitate leadership and accountability.

Because of the Health Department's broad involvement in the delivery of health services throughout the County, it is probably the County department most suited to be assigned primary responsibility for administering the County's EMS activities and coordinating private and public EMS. However, any change in the current role of the Department should await the outcome of the current

task force. It is planned that a report will be made to the Board of Supervisors, which will include an expression of the sentiments of other agencies and private organizations involved in EMS about the appropriate placement of responsibilities for administering the system.

The HSA is the agency most suited for regionalized EMS planning functions because of its current duties of developing a master plan for health delivery services for Fresno County. EMS is an integral part of the overall health services delivery system, and the County's EMS administrative planning must be careful to avoid duplication of HSA effort while remaining consistent with it.

RECOMMENDATIONS

100. The Department of Health should work with the HSA in reviewing and developing a final plan for EMS.

101. The Department of Health should assist the EMC Committee in discharging its responsibilities of reviewing the EMS ambulance services, EMS mechanisms, first aid practices, and in serving as a forum for community input to this evaluation process.

102. The County Administrative Office and the Health Department should work with the current task force to evaluate the present status of EMS, develop recommendations on the future structure of EMS and the role of the Health Department in the EMS system.

SECTION VII. ADMINISTRATIVE PROCEDURES

27. PROCESSING OF GRANT APPLICATIONS

There is a substantial use of grant funds exclusive of ongoing subventions to offset the costs of providing local health care services as shown by the following:

	1976-77	1977-78	1978-79 Estimated
Number of Grants	22	23	25
Amount*	$1,371,836	$2,935,194	$2,052,455

*Represents net award amount receivable from granting agencies--excludes County match. Figures supplied by the Health Department Financial Services System.

This finding examines the grant application procedure currently in use by the Department and its effectiveness in ensuring that grant applications are handled expeditiously and in compliance with Section 2500 of the Administrative Code which governs preparation and submission of grant applications.

The grant procedure used by the Health Department is spelled out in their Standard Operating Procedures (SOP) (#D00200--see Exhibit XI). The overall grant procedure usually involves three phases: preparation of a Notice of Intent, preparation of the grant application, and execution of a contract between the County and the granting agency.

Phase I

Phase I begins with the interested program manager in the Health Department initiating department consideration of a grant proposal by completing Part I of the Notice of Intent (which is obtained from the Program Planning and Development System). He then submits it through his Deputy Director to the Department's Executive Staff Committee, for policy review and approval. The Notice of Intent is a four-copy form required by the County Administrative Code to be filed with the County Administrative Office. A sample is shown as Exhibit XII.

Upon approval, the Executive Staff Committee gives the Notice of Intent to the Program Planning and Development System (PP&D) which sends it to the County Administrative Office for review and approval. The County Administrative Office contacts the Department for financial information necessary to complete Part II of the Notice of Intent form. After consulting with the Department, the County Administrative Office enters the amounts of the County's share, State and/or Federal shares, and total project cost. The County Administrative Office also enters a brief narrative description of what the County's contribution represents (personnel, equipment, services and supplies). The County Administrative Office makes comments and recommends approval or disapproval in the spaces provided. The County Administrative Office retains the appropriate record copy and forwards the second and third copies to alert the Auditor-Controller and the Council of Governments (COG) respectively. The Auditor-Controller's interest is to ensure the fiscal integrity of the forthcoming grant application. COG is the areawide clearing house which checks grant applications to avoid duplication among various agencies. The fourth copy is returned to the originating department. Program Planning and Development, upon receipt of the department copy, notifies the originator of the grant request as to the County Administrative Office's decision.

Phase II

If the County Administrative Office approves the Notice of Intent, the second phase begins when the initiating program manager prepares the grant application and submits it to his/her Deputy Director for review. The Deputy Director forwards the application to three administrative support systems for review in the following order:

System	Review Activity
1. Administrative Services	- Estimates of numbers and classes of personnel, equipment and supplies desired
2. Financial Services	- Funding amounts
3. Program Planning and Development	- Format and narrative content

If exceptions are noted during review by any of the three reviewing systems, the application is returned to the proposing manager to make appropriate changes. The program manager returns the corrected application to the system which identified the exception and the application continues along the sequential review steps. After review is completed, PP&D schedules the presentation of the application

for the Department's Executive Staff Committee meeting agenda. Presentation is made by the proposing system Deputy Director. After Executive Staff Committee approval, the application is returned to PP&D which prepares the transmittal letter from the Department Head to the Deputy County Administrative Officer. After his review, the Deputy County Administrative Officer places the application on the Board of Supervisors agenda. The Board approves or disapproves the application for submission to the granting agency. The Deputy County Administrative Officer notifies PP&D of the Board's decision. Program Planning and Development in turn notifies the initiating program managers or his/her Deputy Director.

If the application is approved by the Board of Supervisors, PP&D submits the application to the granting agency. Upon acceptance of the grant, the granting agency develops a contract which is sent to the Health Department.

Phase III

Phase III begins with the program manager reviewing the contract to determine whether its provisions permit the County to operate a viable program consistent with local objectives. The program manager forwards the contract to his/her Deputy Director who, after similar review considerations, forwards the contract for review and sign-off by each of the three administrative systems for review. The order of review and criteria are similar to those mentioned previously under the grant application review process.

Upon successful completion of these steps, PP&D sends the contract or award to the County Counsel for approval as to legal form. Upon County Counsel approval, the contract or award is returned to PP&D, which, in consultation with Financial Services, prepares a letter to the County Administrative Office and Auditor-Controller requesting the contract be approved as to accounting form by the Auditor-Controller and be placed on the Board of Supervisors' agenda for execution. For Federal grants, upon receipt of a Federal grant award, the Auditor-Controller would prepare a resolution if necessary to increase the Department's appropriations and estimated revenues by the amounts authorized in the grant award. This resolution would be presented at the same time as the grant award for the Board of Supervisors execution by the County Administrative Office. On most State grants, the contract is forwarded to the appropriate State agency for approval and execution. Upon receipt of an executed contract, the Auditor-Controller's Office would prepare a resolution when necessary to increase the Department's appropriations and estimated revenue and the County Administrative Office would present the fully signed contract to the Board of Supervisors for approval.

In the case of a State granting agency upon receipt of the contract, the State granting agency submits the contract to the State Department of General Services for legal review and the State Department of Finance for financial approval. The State Department of Finance signifies acceptance and authorizes funds for payment when claims are submitted against the grant allocation.

Appraisal of the Process

We evaluated the Department's existing procedure to see if improvements could be made without compromising the quality of the grant application product. We also reviewed the Countywide grant application procedure to see if other improvements could be made to expedite the grant application process.

The Department's SOP could place greater emphasis on expediting the grant application through the Department while preserving the integrity of the important reviews provided by the Department's three administrative systems (Administrative Services, Financial Services, and Program Planning and Development). Conceivably the application can be returned to the originating program manager three times before it is acceptable for submission to the Department's Executive Staff Committee for policy review. The emphasis of the SOP is on sequential progress.

While the SOP establishes a grants coordinator responsibility in the Program Planning and Development System, PP&D is the last administrative system to review the application. This could create problems as to who is responsible for monitoring and expediting the procedure prior to PP&D receiving the grant application.

The structure and format of the Department's SOP covering grant applications is probably a source of delay in the process as well:

1. There are no samples of the SOP forms used in the application process such as the Notice of Intent and CA 189 (now numbered CA 424, a summary form for Federal grant application/award notification and other project reviews--used by the State of California and COG for various grant applications).

2. A description of general responsibilities of key persons in the process is placed at the end rather than the beginning of the SOP where it would be highlighted.

3. There are no target processing time limits within which participants should be expected to complete their assigned tasks.

Another concern is that the procedure does not define and describe the review criteria used by the three administrative support systems. This information might help program managers prepare a better quality product. It might also expedite the review process by reducing the corrections needed. Examples of review criteria include:

1. The kinds of personnel, equipment, and services and supplies needed for the program to which the grant pertains.

2. Whether the salaries and costs shown for personnel, equipment, and services and supplies are reflected appropriately.

3. Whether overhead (unless specifically prohibited by the grantor agency) is properly shown.

4. Whether goals and objectives of the grant are consistent with those of the Department.

5. Whether measurement criteria are adequate to assess progress.

6. Whether format or content sufficiently addresses concerns of the granting agency.

Another benefit of specifying these criteria is that it will help explain the role of administrative support services in the processing of grants. By doing so, it may help shift the emphasis in the role of some administrative support managers from that of a screener to a facilitator.

We found other issues in the grant application process outside the Department that have Countywide implications. Sections 2500-2543 of the County Administrative Code cover the preparation and submission of grant applications. A review of this policy suggests possible problems in two areas: 1) the design of the Notice of Intent form (NOI); and 2) clarifying of the roles and duties of the County Administrative Office and Auditor-Controller in the process.

The Notice of Intent form currently does not provide certain funding information of concern to the County Administrative Office and Auditor-Controller. Examples are the accounts in which the Department proposes appropriations and revenues are to be reflected, the kinds and amounts of overhead to be included in the grant application, whether additional personnel, equipment and supplies will be required, and the period covered by the grant, if approved. Currently, the County Administrative Office must contact the Department and fill in total cost and revenue information on the NOI. Delays sometimes occur when the Department has to locate or develop the information after the NOI has left the Department.

The County grant application procedure in the Administrative Code could clarify the roles of the County Administrative Office and Auditor-Controller in the overall process. The Auditor-Controller has begun to play a more prominent role in the grant application process. He has quite properly extended his interests into the review of grant accountability, overhead rates, and the review as to accounting form of the contract which subsequently results from grantor approval of the grant application.

A concern was raised by some staff within the Department for clearer understanding of the Auditor-Controller's role so they could better anticipate his questions and thereby expedite bringing grant proposals to the Board of Supervisors for policy determinations. In some instances, delays to processing grant applications could have been reduced had there been a clearer understanding of the Auditor-Controller's role.

RECOMMENDATIONS

103. That the County Administrative Office work with concerned departments to revise the Countywide grant application process. This would include clarifying responsibilities of all involved departments and making appropriate revisions to Section 2500 of the County Administrative Code.

104. That the County Administrative Office, in cooperation with the Auditor-Controller, redesign the Notice of Intent form so that departments can complete it to meet all anticipated information needs for this stage of review.

105. That the Department strengthen staff support to program managers in developing grants by designating one individual to assist program managers in expediting grants through the Department.

106. That this position assume responsibility for expediting or performing the administrative staff review currently shared by three different support systems within the Department. He should also keep program managers informed of current and potential grant funding sources for health programs as well as due dates for reapplication of continuation grants.

107. This position should redesign Standard Operating Procedures to expeditiously process grants through the Department and in accordance with revised Administrative Code provisions under recommendation 107.

108. That the Health Department Standard Operating Procedure revision include the following:

-- Concurrent review process to avoid delays created by sequential review.

-- Samples of properly completed forms.

-- Processing time parameters for control purposes to the extent possible.

-- Criteria used in each review activity.

-- A clarification that administrative support systems are to suggest and assist in preparing changes to originating program managers to make applications more effective. They should ultimately recommend approval or denial of applications to the Director based upon the review criteria over which they have expertise.

This could greatly reduce the perception held by many managers in the Department that administrative support systems in effect, though perhaps inadvertently, exercised approval or denial authority over grant applications through the administrative screening process.

AUDITOR-CONTROLLER COMMENT

In conjunction with CAO Grant Recommendations No. 101 and 102, a County-wide grant procedure should be developed by representatives from the CAO, Auditor-Controller's Special Accounting Division, and grantee departments. By doing so, these departments can fully document and clarify departmental roles and areas of responsibility and accountability. This would promote the coordination of efforts of the departments and the maximization of County reimbursements. Currently, the lack of County-wide procedures has contributed to varying interpretations of departmental responsibilities and forms utilization.

D0200 - GRANT AUGMENTATION AND SUBVENTION STANDARD OPERATING PROCEDURE

D0210 - Purpose

The purpose of this procedure is to establish a uniform method of applying for grants. It is intended to reduce confusion, to promote coordination and cooperation between the systems, and to reflect Department-wide goals.

D0220 - Definitions

Notice of Intent	- Simple pre-application that must be done on specified form.
Grant	- Funds awarded when application has been made for a specific project.
Continuation	- Grant application that Board of Supervisors has previously approved.
Augmentation	- Increase of funds for an existing program.
Subvention	- Continuous funding to the County that can apply to time limited programs - generally based on population.
Allocation	- An apportionment of funds for a specific program usually by State and Federal agencies.
Contract	- Binding agreement for services or goods between two or more parties.
Grants Coordinator	- Designated person within Program Planning and Development.

D0230 - Practice

D0231 - Preliminary Request Procedure

D0231.1 - A NOTICE OF INTENT must be completed in all circumstances before the Grant Application is filled out. If application is for a Continuation Grant, the Notice of Intent and the Grant Application may be submitted together.

D0231.11 - Prior to following Section D0232 the Program Manager requesting permission to apply for the grant completes a NOTICE OF INTENT form supplied by Program Planning and Development. Notice of Intent must address Departmental goals.

D0231.12 - Program Manager submits Notice of Intent to system's Deputy Director for approval by initials. Rubber stamp reproductions will not be accepted.

D0231.13 - System's Deputy Director forwards Notice of Intent to Executive Staff for review, approval, and Director of Health's signature. In an emergency situation, a Notice of Intent can be put on Executive Staff agenda without previous notice. If there is not time for Executive Staff to hear the Notice of Intent, it will be scheduled as an Executive Staff consent item and go to the Director's Office for approval.

D0231.14 - After Executive Staff approval, Program Planning and Development submits Notice of Intent to Deputy County Administrative Officer for approval by signature.

D0231.15 - Deputy County Administrative Officer notifies Program Planning and Development of his decision by returning Notice of Intent.

D0231.16 - Program Planning and Development notifies Program Manager of Deputy County Administrative Officer's decision by returning copy of Notice of Intent (copy to System's Deputy Director).

D0232 - Grant, Augmentation, and Subvention Application Procedure

D0232.1 - Program Manager takes lead responsibility in completing Grant Application in conjunction with Program Planning and Development, Administrative Services and Financial Services and submits it for coordination, review and sign-off in the following order:

1. System's Deputy Director
2. Administrative Services
3. Financial Services
4. Program Planning and Development

D0232.2 - If there is a need for additional information, clarification, or change, the involved support system will contact the Program Manager stating what changes are required and what changes are not required but desirable.

D0232.3 - The Program Manager will make changes or clarifications and return the Grant Application to the appropriate support system with a corrected copy to the System's Deputy Director.

D0232.4 - After the Grant Application has been reviewed by each support system, Program Planning and Development will schedule the Executive Staff presentation by the System's Deputy Director.

D0232.5 - Executive Staff returns Grant Application to Program Planning and Development for further coordination or submittal to Deputy County Administrative Officer.

D0232.6 - Program Planning and Development writes cover letter for Director's signature and Board presentation and submits Grant Application and letter to Deputy County Administrative Officer for review, signature, and presentation to the Board of Supervisors (the Board Action shall be scheduled according to SOP A0400--Submission of Items to Board of Supervisors by Department of Health).

D0232.7 - Board of Supervisors approves/disapproves Grant Application by Resolution.

D0232.8 - Deputy County Administrative Officer notifies Program Planning and Development of Board of Supervisors' decision by returning Grant Application and Resolution.

D0232.9 - Program Planning and Development notifies Program Manager of Board of Supervisors' decision by returning copies of Grant Application and Resolution (copy to System's Deputy Director).

D0232.0 - If the Grant Application is approved by the Board of Supervisors, it is the responsibility of Program Planning and Development to submit the completed application to the granting agency.

D0233 - Grant Contract Procedure

D0233.1 - Program Manager takes lead responsibility in the Grant Contract procedure, working in conjunction with Program Planning and Development, Administrative Services and Financial Services, and submits it for coordination, review and sign-off in the following order:

1. System's Deputy Director
2. Administrative Services
3. Financial Services
4. Program Planning and Development
5. County Counsel

D0233.2 - County Counsel returns Grant Contract to Program Planning and Development.

D0233.3 - Program Planning and Development and Financial Services submit Grant Contract and request to increase the budget to County Auditor-Controller and Deputy County Administrative Officer for financial review, signature, and presentation to the Board of Supervisors.

D0233.4 - Board of Supervisors approves/disapproves Grant Contract and request to increase the budget by Resolution.

D0233.5 - Deputy County Administrative Officer notifies Program Planning and Development of Board of Supervisors' decision by returning Grant Contract and Resolution.

D0233.6 - Program Planning and Development notifies Program Manager of Board of Supervisors' decision by returning copies of Grant Contract and Resolution (copy to System's Deputy Director).

D0233.7 - If the Grant Contract is approved by the Board of Supervisors, it is the responsibility of Program Planning and Development to submit the completed contracts to the granting agency.

D0240 - Responsibilities

D0241 - Program Manager Responsibilities

The Program Manager is designated by the Fresno County Department of Health and approved by the grantor to direct the project being supported by the grant. The Program Manager is responsible for the proper management and conduct of the project. This responsibility includes not only the scientific, technical, and programmatic aspects of the grant project, but also the financial and administrative aspects of the project as well. The Program Manager will also serve as support to the System Deputy Director during presentation to the Board of Supervisors.

D0242 - Grants Coordinator Responsibilities

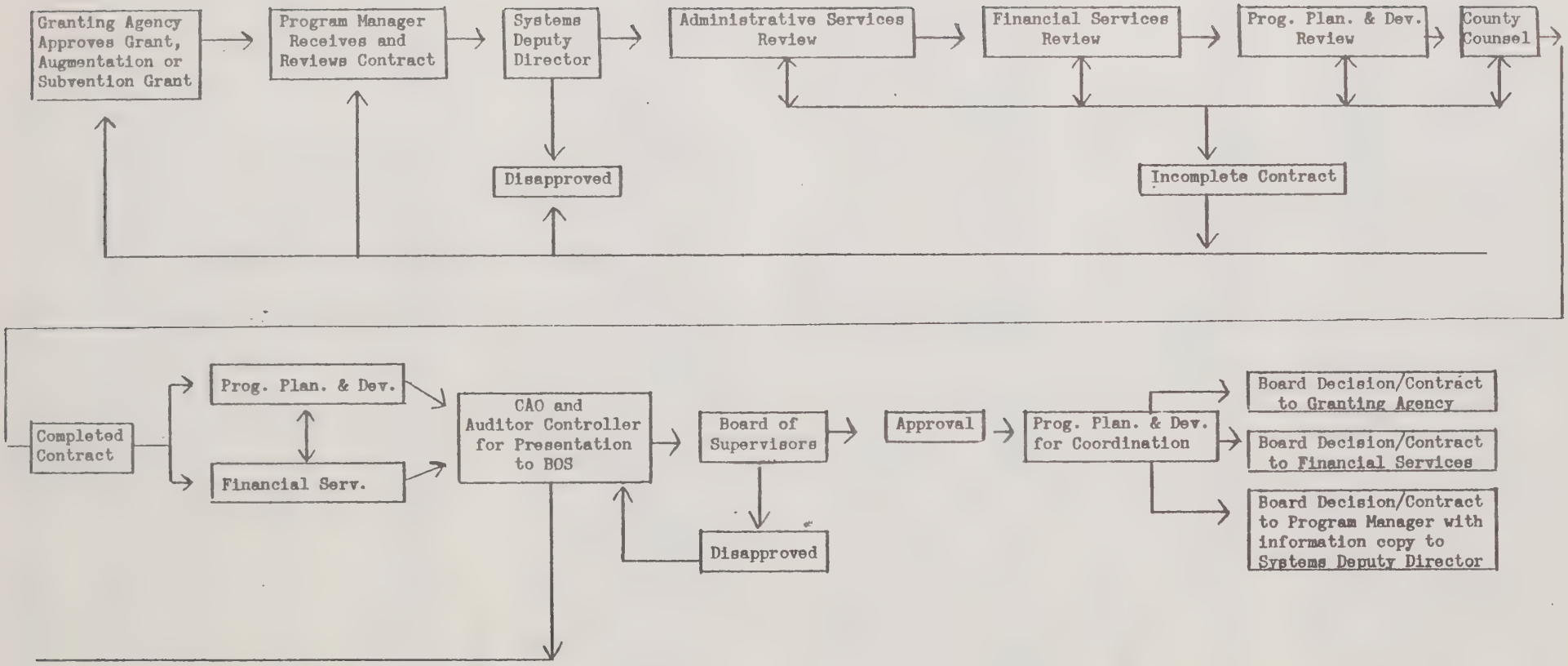
The Grant Coordinator is designated by the Fresno County Department of Health to represent the Department of Health. The Grants Coordinator is responsible for ensuring the validity of the Notice of Intent, Grant Application, and Grant Contract, forwarding them to the proper County Departments for review and approval, and serving as support to the Department of Health during the presentation to the Board of Supervisors.

D0250 - Authority/Reference

Authority for this Grant, Augmentation, and Subvention Standard Operating Procedure is per Executive Staff minutes dated March 22, 1978.

DW:sh
PP&D
3-22-78

GRANT CONTRACT FLOW CHART



GRANT APPLICATION FLOW CHART

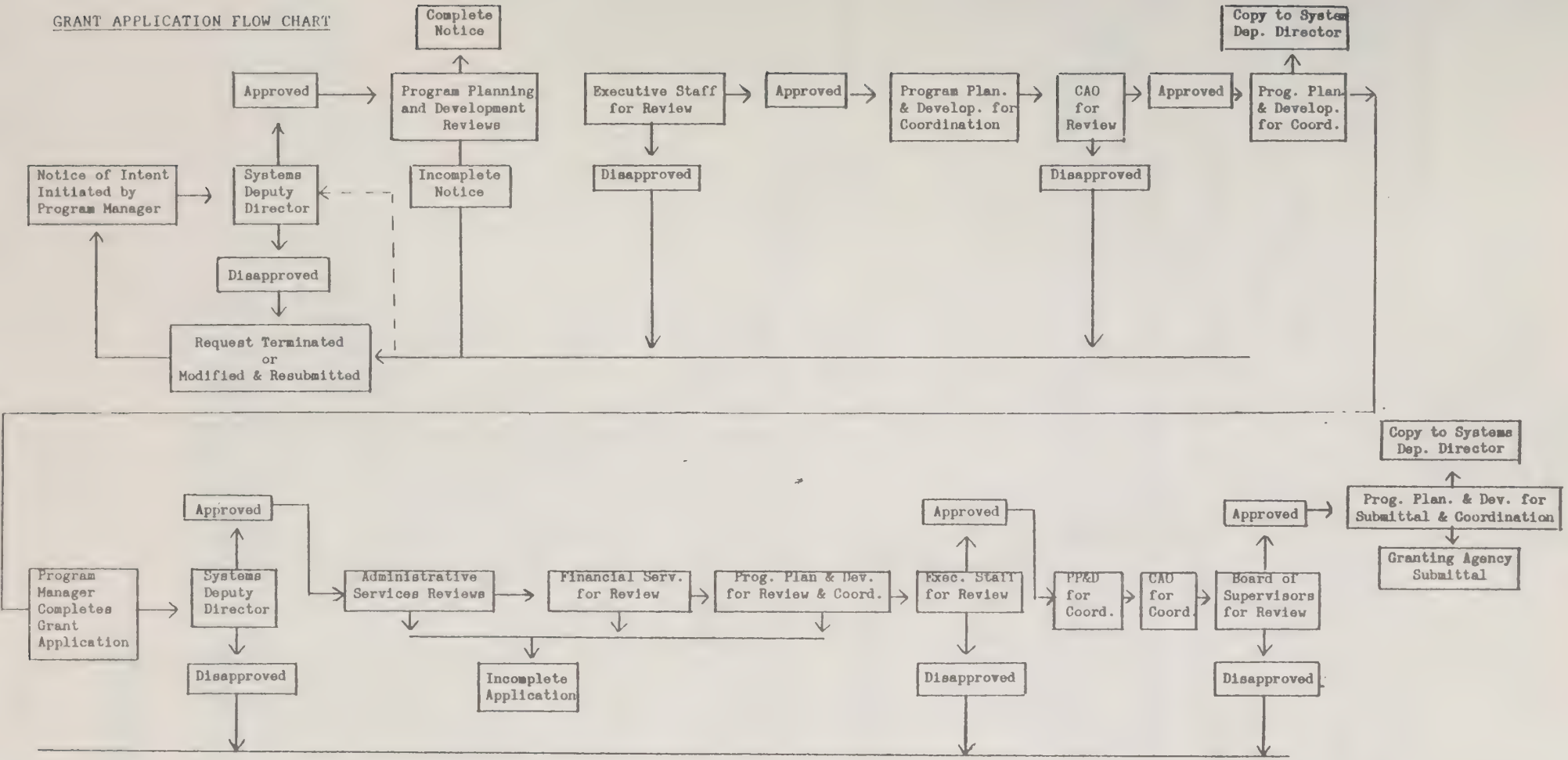


EXHIBIT XII

FRESNO COUNTY
ADMINISTRATIVE OFFICE

NOTICE OF INTENT
GRANTS-IN-AID
(PRE-APPLICATION)

(I) To be Filled in by Department

Date: May 23, 1978

County Department	Title of Project	
HEALTH	Family Planning Clinical Service	
Project Coordinator	**Grantor Agency**	**Deadline for submission to grantor**
Zoe Ann Conley	State of California	

Purpose of Project (Brief)

To provide family planning services, including examinations, modalities and treatment, in the West Fresno area. The State agrees that the western section of Fresno County is an underserved high need area. $60,000 is offered as line-item money for fiscal year 1978-79. Successful family planning programs begun with such funds will be continued with fee-for-service money in subsequent years. A county contribution, or match, of ten percent will be from the present operation.

Authorization by Department Head

(II) To be used by Adm. Office Only.

Date

FUNDING	
COUNTY SHARE—FUNDS	
COUNTY SHARE IN KIND	
STATE SHARE	
FEDERAL SHARE	
OTHER	
TOTAL PROJECT COST	

Comments:

Explanation of County's Contribution:

RECOMMENDATION:

☐ Approval

☐ Disapproval

Submit to Board By: _____

Submit to Grantor Agency By: _____

Authorization by Administrative Office

White — Adm. Office
Canary — Auditor
Pink — Adm. Off. Transmittal to C.O.G.

28. PROCESSING CONTRACTS

During our study we examined the contract processing practices currently used in the Department. We also analyzed their Standard Operating Procedure (SOP) for contract processing in terms of its expediency, and its compliance with Section 2700 of the Administrative Code which governs Countywide processing of contracts. At the outset of our study, we received comments by some managers who expressed their concerns about apparent extensive administrative involvement in reviews and approvals. Such involvement could unnecessarily extend the overall length of time from contract development to final execution and appropriation of funds.

The Department's SOP A1900 prescribes how the various types of contracts are processed.

The Department identifies six types of contracts:

1. Training - With universities for student placement for training and experience.

2. Consultant - With professionals for consultant, lecture, or structured course instruction.

3. Professional Independent Contract Service - With individuals such as physicians, resident managers, who provide service for the Department over an extended period of time.

4. Provider - With purchasers of service for services by the Department of Health. The most common example is a contract resulting from a State grant.

5. Service - For services for the Health Department from other County agencies for a specific product or service. Under Short-Doyle regulations, for example, a written agreement is required between the Department and Computer Services Division for electronic data processing services.

6. Program - With outside agencies to obtain an entire program or specific services. Examples are the Olive Street Bridge, B.A.A.R.T., and Water Surveillance Program contracts.

The Department, in most cases, provides for the funding of its various contracts within each of these six categories in their annual budget request by identifying the services and amounts required for each program where appropriate.

There are some differences in the manner with which each type of contract is processed through the Department. In general, though, this process is as follows:

A service chief, program manager, or a departmental "program liaison" (any employee) may initiate a request for a contract to be developed and submits it to his Deputy Director for approval. If approved, the Deputy Director forwards the request to one of three "contract coordinators" depending on the type of contract. The "contract coordinator" is a designated individual in each of the three administrative support systems (Administrative Services for contracts concerning professional independent services; Financial Services for training, consultant, service and program agreements; or Program Planning and Development for provider agreements). The contract coordinator reviews the request for funding availability within Financial Services and determines whether or not a "Request for Proposal" (RFP) must be prepared. An RFP is required for service and program types of contracts when the specific program or service is available from more than one source.

If an RFP is required, the SOP provides that the initiator and contract coordinator may work with the Purchasing Department to develop one. The RFP provides information for the prospective contractor. This information includes: a problem/need statement, target group description, treatment or service philosophy, a statement of goals the Department hopes to attain, and appropriate administrative and legal requirements for the contractor to follow.

The contract coordinator then schedules a meeting for review of the RFP by the initiator, himself, and an RFP committee comprised of a representative from each of the Department's three administrative support systems. The review responsibilities for each are below:

System	RFP Review Activity
Program Planning and Development	Program consistency
Financial Services	Funds and accountability
Administrative Services	Administrative and legal provisions, such as reporting requirements, equal opportunity or affirmative action requirements

When the RFP committee approves the RFP, the contract coordinator will work with the Purchasing Agent to distribute the RFP to potential contractors.

When proposals are returned to the Purchasing Department, the initiator, the RFP committee, and a representative from the Purchasing Department review the bidder-supplied information. They examine the contractor's objectives and whether those coincide with the goals established by the Department, how the contractor will coordinate services, what criteria he will use to measure and evaluate the progress of services/program activities, and costs of providing the service. The RFP committee will recommend a contractor selection to the Department's Executive Staff Committee which renders final department approval/acceptance of a contractor.

While this RFP process is in the SOP, it has not been performed in this manner. By and large, this is because most contracts are those which are either ongoing or come from a single provider. An exception to this was the Methadone RFP and selection of a provider which was coordinated by the County Administrative Office's Human Services System.

If an RFP is not required, or if the RFP process has been completed, the contract coordinator will draft the contract, confer with others in the Department affected or involved in some way with the contract to ensure completeness, make corrections as necessary, and finalize the contract.

In instances where the Department is the provider, such as for State grants, the contract is drafted by the State following grant application approval and is submitted to the Department for coordination of County review and processing for Board of Supervisors execution.

If the contract requires Board of Supervisors approval, the Department submits the contract according to the Department's SOP A04000 governing submission of items to the Board of Supervisors by the Department of Health.

The contract is submitted to the County Counsel and Auditor-Controller for review as to legal and accounting form prior to its placement on the agenda. The County Administrative Office has requested that all Health Department contracts be submitted for review and sign-off regardless of whether Board of Supervisors approval is required. If Board of Supervisors approval is required, the County Administrative Office after review and analysis prepares the agenda letter for Board action. If Board approval is not necessary, the contract is executed by the appropriate authority. The appropriate authority could be the Department Head for inter-department agreements or the Purchasing Agent who authorizes agreements under $6,500.

The contract coordinator is responsible for ensuring that monitoring of the contract takes place. This is done through periodic reviews by the initiator of reported progress, expenditures, or other evaluative means. Also, the Financial Services System annually reviews the expenditure records and administrative procedures of program or service contracts.

If changes in services, costs, or revenues occur, the initiator contacts the contract coordinator who determines whether the changes constitute significant deviations from the contract as executed. The coordinator may initiate draft amendments to modify the contract.

Appraisal of the Process

Although some managers expressed concern about the amount of administrative involvement in the contract development process, the results of a survey we conducted of line managers did not conclusively support this. It is possible that the perception of heavy administrative involvement in contracts may be affected somewhat by the number of contracts which result from initial grant applications. The grant contract renewal process is not as lengthy and requires less administrative involvement. Nevertheless, we feel that improvement can be made in the process based upon the following information.

Contract Coordinator Responsibilities

The overall responsibility and authority for processing contracts is not really consolidated within each of the six categories of contracts. Determining the status of development of a particular contract within the Department may require contacting a number of sources for information, and extra coordinative efforts among the coordinators.

Standard Operating Procedure

In some cases, facilitative examples or references have not been used. A sample or outline RFP could be attached to the policy to assist in developing one. At the end of the SOP, there is a useful checklist of items which may appear in a contract. However, within the selections of the SOP covering development of the contract, no reference is made to this checklist. This would appear to diminish its usefulness somewhat.

Section A1943.64 requires sequential review and sign-off of program plans for renewal and sole provider agreements by the three administrative support systems. Such sequential reviews can delay processing of a contract within and outside of the Department.

Section A1944 covering contract monitoring does not include policy or procedure to address instances where contractors who provide service to the Department are out of compliance with the executed contract. The policy that contract monitoring will be conducted is spelled out, and responsibilities for this task are assigned, but the SOP does not set forth a policy to address the non-compliance issue. Due to the Department's heavy involvement and financial investment in service or provider contracts, policy should be established that requires the Associate Director be alerted to conditions of non-compliance by contractors. Lack of policy in this instance could affect the timeliness in processing appropriate contract changes or cancellations.

The SOP for processing contracts intersperses statements of policies within procedures. An example is Section A1944.16 which contains a policy statement that makes the Financial Services System responsible to perform annual financial and record-keeping "audits" (in actuality, a records review) for program or service contracts. It would be better to separate explanations of what management wants (policy) and how it is done (procedure) so that sequential procedural steps are unbroken. This results in clearer understanding to the reader.

Contract Processing Outside the Department

We reviewed Section 2700 of the Administrative Code governing processing of contracts and feel that improvements can be made in the following areas:

1. Definition of a contract and what types of documents constitute a contract.

2. Explanation of the Request for Proposal and under what circumstances it is used.

Currently, the Code does not specify these important guidelines. Clarification here would aid the Department in future contract processing activities.

RECOMMENDATIONS

109. That the Health Department singularly place responsibility for coordination of processing each contract type with the proposed Budget and Fiscal Services Division to help accelerate the process.

110. That the Standard Operating Procedure governing contract processing be revised to provide:

    a. A clear line of the sequential steps required to process contracts.

b. Facilitative examples of forms and other documents required in the process.

c. Policy and procedure covering contract monitoring and what happens when service providers are not in compliance with the contract.

d. Concurrent review rather than sequential review whenever possible.

e. Restructuring to separate policy from procedure.

111. That the County Administrative Office work with concerned departments to revise Section 2700 of the Administrative Code governing contracts and agreements. Primary objectives would be to:

a. Define contracts for administrative purposes and specify those documents subject to all or portions of the contract approval process.

b. Establish a policy regarding use of the Request for Proposal.

c. Establish a procedure which facilitates processing contracts without losing appropriate control mechanisms.

AUDITOR-CONTROLLER COMMENT

Recommendation 111a:

We agree that the Administrative Code should define contracts and specify those documents determined to be contracts. This could clarify the classification of purchase order agreements referred to in our comment under finding 24, Psychiatric Residency Program.

Section A1944.16, Standard Operating Procedure:

Section A1944.16 states that the Financial System is responsible for scheduling an annual financial and recordkeeping audit of the program or service agreement early in the contract period.

Although an early audit is very desirable, the policy is unrealistic. A thorough financial and compliance audit of a program or service agreement would require

two to four weeks for each program. The Financial System does not have the audit staff to perform this assigned function. Consequently, the financial monitoring of the agreements is a superficial and uncoordinated effort handled by either the system responsible for the program or individuals in the Financial Services System.

29. DEPARTMENTAL SUBMISSION OF BOARD OF SUPERVISORS AGENDA ITEMS

The Health Department submits items and documents regularly to the County Administrative Office for placement on the Board of Supervisors agenda. We reviewed a sample of 12 of these recent items to determine whether improvement could be made on the quality of information received from the Department. We have two concerns based upon this review: 1) that the correspondence received is not always written keeping the ultimate audience in mind; and 2) in many cases there is no way to determine whether top management has reviewed and approved the item to be submitted for the agenda.

Generally, for most County department business going to the Board of Supervisors, the County Administrative Office:

1. Receives written requests from the departments for placement of items on the Board agenda.

2. Reviews the item to ensure that all necessary information is contained in the proposed agenda document.

3. Prepares the appropriate transmittal documents in a prescribed format using County Administrative Office letterhead. The item then becomes the County Administrative Office's agenda item. Items from elected department heads and most items from the Public Works and Planning Departments are exceptions to the above process and are not rewritten under County Administrative Office letterhead.

In practice, the Health Department does not prepare its own agenda items. Under this process it is understood if not expected that, by mutual County Administrative Office and Department agreement, the Department sends agenda correspondence information to the Deputy County Administrative Officer system coordinator for rewriting into a County Administrative Office agenda item as part of the routine

review and correction process. This is the predominant pattern, rather than the Department originally attempting to prepare an acceptable report on its own. There are, however, two consequences from this approach. One consequence is that there is a duplication of effort because the County Administrative Office drafts a new agenda letter to translate the Department's written request for an agenda item and Board action. The second consequence is that the Department's reliance upon County Administrative Office staff to rewrite agenda transmittal correspondence tends to escalate into dependence. It improves the chances that the Health Department will not do a complete job in preparing its agenda item requests because they anticipate follow-up contact with County Administrative Office staff anyway. This can eventually reduce the quality of the information that it transmitted by the Department and in turn by the County Administrative Office in the agenda correspondence to the Board of Supervisors.

For example, the Department's January 5, 1979 request to the County Administrative Office to place a Utilization Review Program Grant application on the agenda did not explain what utilization review meant. This required a County Administrative Office analyst to spend additional time in contacting the Department to get the basic information about utilization review. The analyst then prepared a separate letter for County Administrative Office signature which explained what utilization review was and the item was placed on the agenda. Because of their distance from many department programs, County Administrative Office analysts tend to catch these ommissions of logic, but important explanations or points of information taken for granted by the Department can be unanticipated by the County Administrative Office staff and left out of the Board presentation. This condition may exist with other departments as well. To the extent that this creates a Countywide problem, the County Administrative Office could consider redesigning the agenda item preparation process.

Seven of the twelve agenda request letters to the County Administrative Office were signed by administrative services assistant staff and (in one case) a secretary. The remaining correspondence was signed by the acting Department Head. There was no way from looking at the seven documents sent by staff to determine whether top management had reviewed and approved the submission of the item to the Board of Supervisors.

The Department has a Standard Operating Procedure (SOP) for internally processing items for the Board of Supervisors agenda (SOP AO400). Briefly, the process is this: any individual initiates the item/document through his system Deputy Director for signature and submittal to the County

Administrative Office. If it is a grant application or budget transfer, the item/document is sent to Program Planning and Development or Financial Services, respectively. When a document relates to more than one system, approval is sought from the appropriate system Deputy Director. Routine agenda transactions, personnel matters, accounting transactions may or may not be submitted to the Director for signature at the discretion of the system Deputy Director. Important items are processed through the Executive Staff Committee.

The SOP does not establish guidelines for determining what documents are important or controversial and which should be directed to the Executive Staff Committee or top management for clearance. The SOP also gives great leeway to Deputy Directors to determine which documents require the Director's signature. This promotes inconsistencies in the manner in which departmental documents are processed, reviewed, approved and/or submitted for Board agendas.

RECOMMENDATIONS

112. That the Department, in preparing Board of Supervisors agenda correspondence, recognize that they are communicating with the Board of Supervisors. This will require they redirect their efforts in the organization, explanation, and presentation of information.

113. That all agenda item correspondence from the Department be in the same format used by the County Administrative Office. This will require the County Administrative Office to work with the Department to explain, if necessary, the expected format and content used.

114. That all agenda item correspondence leave the Department under signature of the Director, or his designee. This will ensure that top management has reviewed and approved the item.

115. That the Department's SOP A0400 on submission of items to the Board of Supervisors be updated with these guidelines.

30. STANDARD OPERATING PROCEDURES

The Department's Standard Operating Procedures Manual contains 24 written Standard Operating Procedures (SOP) which are grouped into four broad categories: administration, client services, finance, and planning.

This finding examines these SOPs used by the Department and assesses their utility based upon criteria explained later in the body of this finding.

The Program Planning and Development System has lead responsibility for coordinating the development of SOPs and maintenance of the SOP Manuals which are distributed to 55 managers within the Department. The SOPs themselves have been developed through committees, task forces, or individuals as the need dictated.

The Department should be commended for putting their policies and procedures down in writing. This shows management's desire to clarify its directions to staff, promote adherence to those directions, and provide consistency in carrying out certain activities. There are, however, several weak points in the Department's SOPs and the SOP Manual, and they adversely affect its usefulness as a tool of management direction.

The SOP Manual

First of all, the manual should contain a description of how and by whom the SOP Manual is maintained, how policies and procedures are developed and placed within the manual, how and when policies and procedures are updated, and to whom manuals are assigned. These are necessary for the successful development and use of a policies and procedures manual, mainly because they aid the user in understanding how policies are developed and implemented within the Department.

Also, there is presently no index which allows the reader to look up a subject contained within an SOP. An index can reduce time spent by the user in searching for the information desired. The Department intends to produce an index when the number of SOPs in the manual justify its need. Yet there is enough information of sufficient variety in the SOPs to warrant the inclusion of an index in the manuals now.

The Standard Operating Procedures

We reviewed 12 of the 24 SOPs in the manual and found a number of factors which reduce their effectiveness. These factors include: incomplete description of practices, inclusion of policy within a procedure, exclusion of policy where needed, limited reference information, need for facilitative examples, cumbersome language, and inconsistencies between stated purpose and practice.

Incomplete Description of Practices

Within the 12 SOPs, we noted 21 instances where practices were not written down completely. We refer mainly to breaks

or ommission in sequence of steps, and not specifying points of responsibilities in the organization. An example of this appears in Section A0136 under SOP A0100 - Personnel Procedures which states:

> "Intra-Departmental Transfers - Persons desiring to transfer within the Department may file a confidential application in the Personnel Office."

There is no statement in the SOP which explains what actions the Personnel Office takes with the application or whether the requestor is notified of further action taken.

Instances of not specifying what positions were assigned SOP-identified responsibilities seemed to be more prevalent in areas that involved administrative support systems rather than in line systems.

Effective procedures provide complete documentation of the steps necessary to meet management policy in a given circumstance. They try to explain who does what, when, where and why in sequence so that users are fully aware of the entire process and their relationship with it.

Policy Obscured Within Procedure or Policies Lacking

In our analysis of the 12 SOPs, we noted 25 instances where policies were interspersed within descriptions of procedure and three instances where policy explanations were only implied or lacking altogether. For purposes of staff understanding and compliance, successful policies and procedures distinguish policy (what management wants) from procedure (how it is done) so that all explanations of purpose and goals are in one portion of the SOP and all steps and responsibilities in the procedure in another. This permits clearer understanding of the policy management wants implemented, and distinguishes policy from the proper procedural steps and sequence to be followed in its implementation.

Limited References, Need for Facilitative Examples

We noted 15 instances where references were limited or incomplete. This refers to such things as: 1) mentioning forms without specifying their actual title, form number, or attaching a sample; 2) vague references to "County regulations" without specifying the applicable code section number (Section A0231.4 in the Travel SOP is an example); 3) omission of definitions or explanations. For example, Section A0137.24 (Personnel Practices) requires review of grievances by the Employee Conciliation Committee, but does not explain to the reader what this committee is, or does, or why it plays a role in the grievance procedure.

Any uncertainty or ambiguity left in an SOP tends to create a user dependence upon those who play more prominent or pivotal roles in the applicable processes within the Department. This can cost additional staff time in resolving questions and correcting subsequent errors.

Cumbersome Language

We noted 43 instances where one of the following occurred:

1. Passive rather than active writing style to convey policies and procedures.

2. Use of "permissive" words or phrases like "ought to," "should," and "may" to recommend action permits ambiguity.

3. Use of future tense to express current requirements (will be, are to be).

4. Use of awkward sentences.

An example of #4 above is Section A0635.1 - Lunch Schedules which states:

> "All employees regardless of working hours shall have lunch periods of not less than one-half hour with approval of their supervisor."

This could mean that for lunch periods over one-half hour, supervisory approval is required, or that for lunch periods less than one-half hour, supervisory approval is required.

Clarity is important if SOPs are to be used successfully by the Department. Sentences should be clear, concise, active, and expressed in the present tense.

Other Factors

We noted other instances that diminish the effectiveness of the Department's SOPs:

1. A form was not mentioned in the SOP to which it was attached (SOP A0100).

2. Providing two methods to record long distance phone calls when the stated purpose of the SOP was to establish a uniform method.

3. Instances where an inordinate amount of administrative control would appear to hinder rather than facilitate the function covered by the SOP. (Example: SOP A0900 - Purchasing, Ordering.)

4. Unnecessary duplications. (Example: SOP A0100 uses an eight page flow chart to assist in explaining a ten page SOP.

RECOMMENDATIONS

116. That the Department assign responsibility for developing and writing SOPs to one unit within the recommended Information and Evaluation Services Division of the Administrative Services System.

That SOPs be revised to:

a. Distinguish between policy and procedure.

b. Clarify and state procedures sequentially to provide employees with the total picture of a particular process.

c. Provide facilitative examples of forms required in the procedure.

117. That the SOP Manuals include an index, an explanation about how SOPs are developed and adopted, maintained, and updated.

118. That department management pay closer attention to the review of the SOP documents to ensure that they meet the objectives of management. This should include broadly circulating SOPs in draft form to personnel involved in carrying out those operations covered by the document for review and comment. This should include persons outside the immediate task force assigned to develop the SOP.